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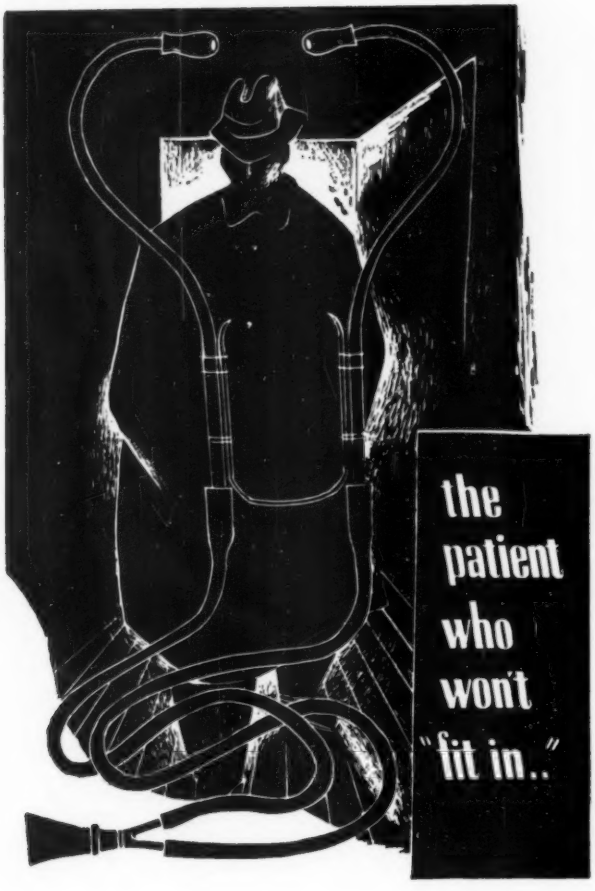

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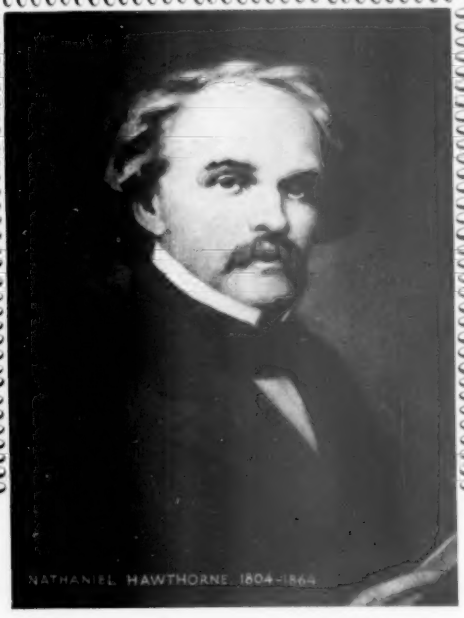

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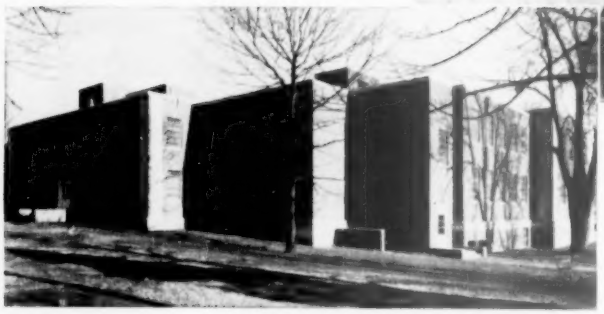

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THE ASSESSMENT OF MENTAL HEALTH[1]

JOSEPH W. EATON, PH. D., DETROIT, MICH.

At a recent meeting of some of the nation's outstanding psychiatrists, doctors, sociologists, and anthropologists, all researchers in the field of mental health, someone posed a question: "What is mental health?" There was silence.

It was clear to all those present that the social sciences have no generally accepted criterion of mental health. "No two authorities agree," is the conclusion of James Clark Moloney, who has given this problem his attention(1).

SCIENCE AND QUACKERY

The social scientist is at a disadvantage compared to the physician or the pharmacist in being recognized as a man of knowledge. He cannot meet his public with the symbolic reassurance inherent in an "antiseptic" white coat; he has no pills, injections, or operative devices that will bring alleviation or cure with impressive statistical predictability.

Unfortunately for both patients and society, social scientists *and* medical men are equally far from a scientific understanding of mental illness. Both grope in a field of considerable statistical uncertainty when they deal with functional mental diseases. "Preventive psychiatry is in its infancy," to quote W. C. Menninger's conclusion(2). The discovery of universal, precise, or moderately certain knowledge in this area is largely a matter of pious hope and promise; or as Dorsey puts it(3):

> Most issues regarding the person have been live ones and therefore must be considered as more in suspension than settled. . . . . To many pressing problems of personality adjustment there are no final answers or solutions. Where uncertainty is the best that man can now attain, to recognize that it exists is the first step in its solution.

Much of the public does not really want to hear such frank acknowledgments of doubt and uncertainty. A patient with a mental problem wants to believe that science can definitely cure him. He usually does not come to the experts except as a last resort, after his family, friends, the bartender, or the minister had to give up in their efforts to help him. The patient wants to infer godlike powers in the expert; his neurotic needs create a transference relationship that often assumes the manifestations of a religious faith. Psychiatry becomes a gospel. Freud's writings or Horney's latest book becomes his bible and his own therapist the ordained high priest. The great expense of most psychiatric care further adds to the needs of the patient to rationalize justifications "that he is getting his money's worth."

Judges of Probate and prison administrators have similar needs to create "experts" in a field where they feel themselves inadequate. Their duties include the making of weighty decisions concerning psychopaths and sex perverts. Not knowing what makes these deviants tick, they look for someone expert to shoulder the responsibility. Most often psychiatrists are selected to wear what Moloney calls a *magic cloak*(4). They wear it well, not necessarily because of any demonstrated superiority of knowledge of mental health, but because of the halo effect of their medical training. The public has confidence in the remarkable curative powers of drugs and surgery. It transfers this prestige to psychiatry.

The neurotic needs of patients and public health officials to find mental health wizards are a great temptation to scientists to respond appropriately. The rewards in terms of income and prestige are great. Some scientists also experience much personal insecurity because they practice in a relatively undeveloped field of knowledge. Moloney expresses this sentiment when he writes:

> Many analysts intuitively sense that they are wearing a "magic cloak." To protect this investiture, it becomes incumbent upon them to protect the omnipotent characterization affected by their analy-

[1] This paper is the product of preliminary research for Project MH-255, "Cultural and Psychiatric Factors in the Mental Health of the Hutterites," an investigation supported by a research grant from the National Institute of Mental Health, U. S. Public Health Service. The writer is indebted to Dr. Olin Anderson, who read a draft of the manuscript and made several suggestions.

From Wayne University, Department of Sociology and Anthropology.

tic fellows. To see through the other analyst might lead, eventually, to a terrifying insight into their own counterfeit assumptions. This would be dangerous. But usually anxiety blocks this introspective evaluation of their assumed omnipotence.

Social forces press upon the psychologist and sociologist for a similar self-rationalization of omnipotence, although their lack of medical training does not give them the psychiatrist's derived prestige and halo.

Scientists in the field of mental health, even when fully conscious of their limitations, are understandably reluctant to put too much public emphasis on their doubts and uncertainties. There are too many charlatans who know much less, who are willing to fill the gaps. Scientists are faced with a public relations dilemma. It arises from the acceptance of pronouncements in the field of mental health from almost anyone, regardless of his qualifications. Newspaper writers, preachers, or "Mr. Anthony" dispose of the most complex personality problems, without "ifs" and "buts," and with refreshing finality. The fact that they often do this in simple intelligible English lends further weight to their pronouncements. The average layman, who would never think of fixing a leaky faucet without calling a plumber, is often quite confident of his capacity to resolve social or psychological issues. As Stouffer(5) points out:

> In a society which rewards quick and confident answers and does not worry about how the answers are arrived at, the social scientist is hardly to be blamed if he conforms to the norms. Hence, much social science is merely rather dull and obscure journalism; a few data and a lot of interpretation.

Conceptual Confusion

Experts do not agree on the meaning of mental health. Psychiatrists and clinical psychologists have personal criteria of the requirements to consider a patient "cured." These criteria arise out of their experience and social value orientation. No common denominator for these definitions can be found.

Lillian Blumberg, in a recent challenging article, "Does Psychoanalysis Cure?"(6), presents a summary of the doubts among psychoanalysts concerning their results. No systematic assessment of psychoanalytic treatment has ever been attempted. The most significant effort in this direction is a survey by Oberndorf, who sent a questionnaire to 24 leading American analysts, all of whom had more than 20 years of experience. Blumberg quotes Dr. Oberndorf(7) that the nature of the 18 replies received was

> . . . . very disconcerting. There was nothing upon which they agreed, not in the type of case best suited for analysis, nor the methods of termination, nor the results, nor how many patients were helped through analysis to avoid serious mental illness. This . . . added to the already great confusion concerning technique and type of case to which psychoanalysis should be applied.

The difficulty is further illustrated by Kelly and his collaborators in the study, "The Selection of Clinical Psychologists." The clinical judgments of psychologists were found to have little consistency when those of different clinicians are compared. In their preliminary report this research team of some of the nation's most outstanding clinicians points out(8):

> We all began our work in assessment with fairly strong prejudices (conscious or unconscious) about the merits of our pet tests or techniques and the shortcomings of others. When we were forced to consider all kinds of materials on each candidate, we began to discover that even our preferred techniques were fallible indeed—that no one of them gave us more than a very partial picture of the candidate being studied. Then as analyses of the resulting data have become available, we are confronted with the painful conclusion that there may be but little relation between our confidence in the technique and its demonstrated effectiveness even in the hands of those who believe most in it.

Each clinician, be he a physician, psychiatrist, psychologist, or just John Q. Public, evaluates people he meets in his daily life. All operate wth a somewhat personal, vague, and usually none-too-conscious notion of what mental health is. Their communication is further handicapped by a lack of a common language of terminology and meaning.

Mental health, as a scientific concept, does not now exist. Most of those who are professionally concerned with its understanding evade the issue by talking about ill-health. They presume the existence of health unless what are to them negative symptoms occur.

Limitations to Clarification

The reluctance to define a mental health concept does not reflect a conspiracy of

silence on the part of scientists. Research in this field is faced with 5 obstacles of theory that greatly limit the potentiality for clarification:

1. The first obstacle arises from the fact that mental health is part of general health. A person's mental state is a function of the interplay of somatic and psychosocial factors. Psychosomatic elements are suspected in the vulnerability to even such ailments as tuberculosis, whose immediate organically causative bacilli have been clearly defined(9). In mental health, the contribution of organic, psychological, and social and ideological factors defies specification. There are no methods through which the factors can be observed in isolation so that their relative causal significance might be estimated; often the factors themselves cannot be identified easily through specific criteria that would lend themselves to measurement, comparison, and correlation.

A study of mental health must take place within the total pattern (field or Gestalt, if one prefers these terms) that ties culture and personality into a functioning entity. We may abstract some elements for special observation, but never without realizing that this introduces some artificiality.

2. A second difficulty arises from the fact that environmental frustrations, to which some persons respond in ways considered "unhealthy," are the very occasion through which others demonstrate what is considered "normality." Mental health is not the absence of frustrations. It shows itself in the manner of handling them. The loss of a job or a love object will reveal personal disorganization for some: to others it will provide a stimulus for demonstrating their maturity and feelings of personal adequacy. Frustration and gratification are two sides of a coin (10). The juiciest steak seems unpalatable to the satiated stomach. The intensity of satisfaction—be it in business, love, or scientific pursuit—is a function of the difficulties that had to be overcome in the process. In death, when frustrations stop, so does life.

The degree of mental health cannot therefore be measured by external blockings that might be studied objectively; it is a function of subjective reaction to these blockings. Their description and measurement are more elusive.

3. The third complication lies in the fact that mental health is a matter of degree. This imposes inexactness. A definition cannot effectively include the gradualness with which mental health merges into illness, while still distinguishing between the two. A behavior, such as a delusion of hearing heavenly voices, may characterize mental illness for some, yet be hardly a handicap for a revivalist preacher who can muster balancing factors to remain in touch with reality. All of us have an occasional touch of mental illness, when extreme disappointment or catastrophe must be faced. In reality, mental health merges imperceptibly and gradually, like the colors of the spectrum, into mental illness. Any simple definition of these concepts must therefore involve the kind of distortion that always occurs when two dichotomous concepts are formulated.

4. The fourth complication lies in the unwarranted assumption that knowledge derived from acute mental diseases can provide good clues to the causal factors of positive mental health.

Research now is concentrated largely on the extremes of human behavior. Mental health, however, involves not only these extremes. Little attention has been given to incipient symptoms of illness. They cannot be spotted easily because they have no dramatic quality. For example, while it may be true that many children exhibiting serious behavior problems have a history of early compulsive toilet training, many a child so coercively trained develops no similar symptoms of maladjustment in later life. The measurement of mental health of those who are outside of mental institutions, and for the most part lead a "normal" life, is difficult in the absence of validated symptomatic criteria of graduated seriousness. There are no diagnostic tools, like the thermometer, that measure mental "fever" to a fraction of a degree.

5. The fifth complication is found in the fact that health is not a static quality. It changes through time. A physician's findings tend to lose validity as time marches on. Many mental illnesses are cyclical. Some

patients who suffer from serious episodes of alcoholism, depression, or mania appear periodically to be perfectly sane. Often they are released from hospitals on that basis, only to be brought back later. Landis and Page estimate(11) that "one fifth of the annual admissions to state mental hospitals in the United States are patients who have been previously hospitalized one or more times."

The more "normal" individual also is subject to variations of emotions. A definition of mental health must be flexible enough to allow for transitory feeling of being "blue" or depressed, for mild delusions or hallucinations that can be experienced by mentally "normal" persons without necessarily qualifying them for admission to a mental hospital.

It is clear that the lack of definition of mental health is related to relativities inherent in human nature. Man and his conditions of living are found under many varying conditions, which defy neat and logical classification. At the present state of science, we know of no effective method of satisfactorily overcoming the previously mentioned limitations. In summary:

1. Mental and physical health form a functional continuum and cannot be separated operationally into "pure" types.
2. Mental health is a function of the culture and environment in which a person lives.
3. Mental health is a matter of degree. None of us possess it to perfection.
4. Mental health is more than the absence of clearly identifiable symptoms of mental illness.
5. Mental health is not static. It changes with time.

Several criteria of mental health are being used despite these limitations. Five major types of concepts can be distinguished. They are, as any definition must be, based on some arbitrary standards. They are not mutually exclusive. Often two or more are employed in the same research. The following is an attempt to review each criterion and its claims to validity within our own and other cultures.

Criterion No. 1. Mental Health Judged by Clinical Insight

"Normality" is a highly personal concept. No generally accepted norms exist. Mental health is whatever the practitioner thinks it is. Usually the technicians cannot verbally or operationally define the concept on which their judgments are based. "We have had years of experience," or "It is our clinical judgment," might be their explanation. Many important diagnostic decisions in courts, hospitals, schools, and private practices, which have a vital influence on the lives of individuals, are made on the basis of such personal standards.

Many of these personal judgments are not made without some reference to other criteria, particularly psychological tests, projective tests, and psychometric measurements. During the training period of psychiatrists, social workers, and teachers, supervisors also attempt to validate the intuitions of trainees against the judgments of recognized experts. During internship they work under the supervision of others. To an extent, this practice develops some common values for arriving at clinical decisions, particularly within each school of thought.

These standards, however, are quite vague. Once the professional education has been completed, most experts in the mental health field operate independently. For their standards of clinical insight they need refer to no one but themselves.

To the extent that the professional education of doctors, psychologists, social workers, teachers, and other mental health practitioners in many cultures is based on common scientific principles, some cross-cultural consensus in the personal judgments of experts can be expected. However, the opposition to psychoanalysis in Nazi Germany or Russia, the objections to Freudian personality mechanisms in Catholic circles, as well as the prevalence of ideological sects, such as Freudians, Neo-Freudians, Rankists, and Marxists indicates that there is as yet not too much consensus on the theoretical foundations for the making of personal judgments. The mental health judgments of experts do not now lend themselves readily to comparison, either within our culture or cross-culturally.[2]

[2] Proposals for the assessment of the effects of psychoanalytic treatment have been made by Phyllis Greenacre and Lawrence Kubie, although both of these psychiatrists recognize the considerable technical, financial and vested interest obstacles inherent in their plans. See reference 12.

Criterion No. 2. Mental Health as an "Ideal Type" Personality Description

Some students of mental behavior have ventured to express their personal judgment as a logically precise concept. They have set up an *ideal-type* [3] cluster of personality traits as a guide to their clinical evaluations.

Erich Fromm(13) defines mental health in terms of social function:

> The term normal or healthy can be defined in two ways. Firstly, from the standpoint of functioning society one can call a person normal or healthy if he is able to fulfill the social role he is to take in that given society—if he is able to participate in the reproduction of society. Secondly, from the standpoint of the individual, we look upon health or normalcy as the optimum of growth and happiness of the individual.

Rennie and Woodward(14) equate mental health with individual "maturity."

> In very simple terms, a mature and mentally healthy person is one who (1) respects and has confidence in himself and because he knows his true worth wastes no time proving it to himself and others; (2) accepts, works with, and to large extent enjoys other people; and (3) carries on his work, play, and his family and social life with confidence and enthusiasm and with a minimum of conflict, fear and hostility.

Karl Menninger's concept emphasizing happiness is quoted in a leaflet(15) issued by the World Federation of Mental Health:

> Let us define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment—or the grace of obeying the rules of the game cheerfully. It is all of these together. It is the ability to maintain an even temper, an alert intelligence, socially considerate behavior, and a happy disposition. This, I think, is a healthy mind.

Preston, who as Commissioner of Mental Hygiene for the State of Maryland wrote a popular book on the "Substance of Mental Health"(16), gives this definition:

> Mental health consists of the ability to live (1) within the limits imposed by bodily equipment; (2) with other human beings; (3) happily; (4) productively; (5) without being a nuisance.

In the light of the history of psychiatry, which quite recently has blossomed so richly in many places and many directions, this semantic confusion is to be expected. As Lawrence Kubie(17) points out:

> Our [psychiatrists'] technical speech has grown up in many different clinical centres, in different lands, in different languages, sometimes in periods of rapid shift and growth, sometimes as the discipline lay fallow. Consequently the garden of our language is full of weeds.—The problem of communications alone presents imposing difficulties.

To the extent to which there is consensus of meaning in language, these "ideal type" definitions provide a measure unifying the criteria of different experts. The use of written case records in hospitals or private practice is possible because language does convey much common meaning, despite its semantic limitations as a means of communication between different human beings. Semantically described personality traits play a part in giving some common denominator to the personal judgments of mental health practitioners.

Criterion No. 3. Mental Health as a Self-Judgment

Subjective feelings of happiness are regarded as an indication of mental health. Conversely, the experience of anomie and personal frustration often is a symptom that drives individuals to seek psychotherapeutic help. The degree of disappearance of psychic pain is accepted by both the individual and his physician as a valid index to his mental state.

The validity of any mental health concept depends, at least to a degree, on individual concurrence with its meaning. It cannot be accepted as the only criterion. Few inmates of our mental hospitals would remain there if their judgment of their state of health were accepted as valid. In some patients' views, "the doctors are the ones who are crazy." But in judging more normal persons,

[3] A method of social research popularized by Max Weber. *Ideal type* refers to the construction of certain elements of reality into a logically precise concept. It involves an abstraction of the most essential components of an experience, leaving out the details that give each event, no matter how common it may be, an aspect of uniqueness. In the qualitative areas of the social reality, the use of ideal type concepts makes a comparison of events possible even though they differ in many details. Ideal types buy comparability in essence at the price of accuracy in detail.

the view of the patient cannot be similarly ignored. A person suffering from a psychosomatic headache is not cured until the patient (not the doctor) finds that the ache is gone. Self-rating must be part of any validity criterion of mental health.

Feelings of happiness, no doubt, vary with the current moods of a person. However, reliability data from self-scoring tests of adjustment are sufficiently high to indicate that there is some stability in a person's self-rating.

Self-ratings of happiness are a function of individual expectation and values. Ratings of one person are not necessarily comparable to those of others. However, persons in the same social group or culture are likely to be responsive to similar values. They are the product of common processes of socialization. This element gives some common content to their self-judgments of mental health.

The self-judgment criterion permits a cross-cultural examination of mental health. One can study the tendency of a society's folkways and mores to encourage subjective feelings of happiness among its members. Cultures, no doubt, differ in the degree to which they foster feelings of happiness or malaise among their members. Some cultures require more inconsistencies than others in the rôles that each person must play. Many regard the Western cultures productive of much inconsistency in the rôles a member is expected to play(18), in contrast with the more integrated folk cultures like the Hutterites(19) or the Samoans(20).

The possibility of comparison of self-conceptions regarding mental health of samples taken from different cultures, classes, or social strata makes the criterion of self-judgment an important research tool.

Criterion No. 4. Mental Health as a Group Judgment

The feeling of happiness in most people is a function of their degree of conformity to the values of the group with which they identify themselves. This is the meaning of "adjustment," a concept that pervades much of the popular literature on how to become a "good," "sociable," and "all-around" personality. There are wide variations in cultural tolerance for deviants. For example, homosexuals, who are considered to be dangerous sex criminals in our culture, are reported by Kroeber and Williams(21) to be generally accepted in many "primitive" groups. A paranoid like Adolf Hitler, who in the United States might have done his ranting safely behind the barred windows of a mental hospital, was the embodiment of everything admired in Germany.

Cultural relativity plays a much larger rôle in the fields of mental health and illness than in most other fields of medicine(24).[4] An inflamed appendix has a fairly uniform meaning in all cultures that recognize life as a desirable value. If left untreated it is a threat to life. Not so in the mental health field. Even in the case of very unusual behaviors, like suicide, one cannot find complete cross-cultural uniformity in its interpretation. Kingsley Davis(23) presents evidence that in the United States the mental hygiene movement has accepted the democratic, worldly, ascetic, individualistic, utilitarian, and competitive values of the middle class. Its criteria for mental health reflect strong personal and class biases and are in part rejected by other sections of the population. Karen Horney(24) emphasizes that, even within our culture, concepts of mental health and illness vary considerably through time:

> . . . . If a mature and independent woman were to consider herself a "fallen woman," "unworthy of the love of a decent man," because she had sexual relationships, she would be suspected of neurosis, at least in many circles of society. Some forty years ago, this attitude of guilt would have been considered normal.

A most dramatic demonstration of the cultural relativity of mental health concepts

[4] This view is somewhat at variance with the opinion expressed by Ruth Benedict(22) in an otherwise insightful article. "Though for comparative discussion lists of specific acts found in various societies are inadequate indices of mental health, recognizing this fact does not mean that the criterion of mental health which emerges is *relative* and *cultural*. There is a universal criterion; it is the one Pavlov used in his famous experiments: 'The loss of ability to go on functioning'." It seems to the writer that traits required for good functioning certainly are not universal. Ruth Benedict's many anthropological studies illustrate this admirably.

was provided in the recent trial of Mr. Alger Hiss. The testimony of psychiatrist Carl A. L. Binger and psychologist Henry Alexander Murray concerning their doubts of the state's chief witness, Whittaker Chambers, was challenged by the prosecution as being without scientific validity. An impressive array of unusual behavior and character traits of Mr. Chambers was offered as evidence of his insanity. However, the prosecution showed that some of these behaviors, like staring at the ceiling during conversation, are also commonly found in normal people, including the expert who offered the testimony! The trial showed that there are no generally accepted medical, psychiatric, or psychological standards that could be applied to the case. It was left to the value judgment of 12 *nonprofessional* jurors to rule, among other things, on the sanity of Mr. Chambers (25).

Three types of group judgments should be distinguished: First are the judgments of "experts," such as doctors, lawyers, psychologists, sociologists, teachers, medical men, or other culturally accepted authorities of science. Second are judgments of family and close associates of each individual. They constitute the audience toward which most actual behavior is oriented. They are the "lay experts" by virtue of intimacy with the individual. Third are the judgments of the society at large, as expressed in its folkways and mores. Court juries are often more guided by this type of cultural consensus than the opinion of scientists or close associates of the person in question.

In cultures where relatively few inconsistencies arise from contradictory values and rôle expectations, there will be much agreement on the meaning of the behavior of an individual, whether the judging is done by experts, close associates, or persons who typify the dominant mores of the group. In the American melting pot, nationality, race, locality, occupation, and status groups often operate on the basis of expectations that show considerable variation.

A definition of mental health utilizing group judgment can be used in cross-cultural comparisons, even though the meaning of the concepts differ. It permits an examination of the degree of positive mental health fostered by the folkways of a group measured in terms of their standards. One can study the support that an individual can expect from the values of his group, as he goes through life and meets its problems. The writer agrees with Hallowell(26) in suspecting that differences in pressure imposed upon an individual by cultural expectations bear some relation to the incidence and nature of mental breakdowns in different cultures, irrespective of situational or physical factors.

Criterion No. 5. Mental Health as a Statistical Norm

In a lynching mob, individuals give vent to sadistic expressions that would constitute adequate cause for a criminal conviction or confinement in a mental hospital. Mob sadism is regarded with approval by some groups. There is "normality" in such actions which, if committed by an isolated individual, would be considered "abnormal."

The concept of normality pervades much of the research in the mental health field. Tests of adjustment, both psychometric and projective, are partly validated on the basis of the normal distribution of behavior in line with the theory of probability. Statistically significant differences of groups in response to specific questions in the Rorschach, Thematic Apperception, Minnesota Multiphasic, and the Cornell Indices, are used as criteria of validity.

There is much justified doubt concerning the use of such test norms in the measurement of mental health. None of the tests has been so effectively standardized that mental deviants can be effectively detected with their aid. Despite some encouraging research results, the tests can be used only as diagnostic tools, and then only with the utmost caution. Their validity is greatest for individuals who are at the extremes of the mental health–illness continuum.

Mental health is sometimes defined operationally in terms of statistical norms or averages. This is particularly true for mass screening of large groups in schools, hospitals, or before induction of soldiers into the U. S. Army. The use of this criterion, in the absence of more precise methods, is justified on the basis that it has some statistical va-

lidity. A "normal" score on the "Cornell Selectee Index" is no guarantee that John Doe is not psychotic. But for a large group of John Doe's, the chance of having psychotics included within it is considerably reduced by this objective screening device(27).

Most cross-cultural mental health studies are based on this criterion. Landis and Page (11), for example, make 2 types of statistical comparisons: (1) admissions to mental hospital and (2) rejection for military service for reasons of mental illnesses. With the expansion of universal health insurance in many countries, statistical comparisons of *nonhospitalized* mental cases may also become available.

There are numerous limitations to statistical comparison. Mental disease rates depend greatly on the availability of hospital facilities, diagnostic standards, and the willingness of the population to keep milder cases of illness in the family under home-care. Military conscription rejection rates have meaning only for young men. They vary greatly with medical standards and the urgency of the need for soldiers.

Statistical comparisons become even more difficult with mental health conditions of "primitive" cultures. For the most part, their people have no access to mental hospitals. They have no doctors skilled enough to recognize most manifestations of mental illness. Hallowell(28), Cooper(29), and most recently Linton and Redlich,[5] who combed ethnographic literature, found woefully little evidence on this subject, a fact not surprising since few anthropologists have had enough psychological or psychiatric experiences to make relevant observations.

The limitation of the statistical criterion lies in the fact that it measures only the publicly recognized incidence of mental illness. But it does give an approximate account of the readily visible costs of mental breakdowns to a society. Statistics also provide a rough measure of a group's preoccupation with the absence of mental health. To the extent to which the standards of judgment used in admission to hospitals or medical rejection for military service are similar in different countries, the statistical criteria also permit cross-cultural comparisons of the mental health proclivity.

[5] Ralph Linton of the department of anthropology and Fredrick C. Redlich of the department of psychiatry of Yale University are currently supervising a comparative study of psychotics in different racial and cultural groups with the help of a grant from the Viking Fund.

Mental Health as a Value Judgment

Our examination of the efforts to assess mental health shows no universally acceptable criterion. The conclusion of Lord Blackburn, the noted English legal authority of more than half a century ago, still holds. Speaking in the House of Commons he declared(30):

> I have read every definition of [insanity] which I could meet with and never was satisfied with one of them, and I have endeavored in vain to make one satisfactory to myself. I verily believe it is not in human power to do it.

Mental health is a conceptual abstraction. It is a relativistic assessment of man's relations to himself, his society, and his values. It cannot be effectively understood in isolation from the other multifactorial phenomena that constitute the person as he functions in society.

Mental health is never studied as such. We know it only through its manifestations. Five functional criteria have been suggested, all of which are used in current studies of mental health: personal insight, "ideal type" personality description, self-judgment, group judgment, statistical norm.

Each of these criteria is applied in some situations. Often, several criteria are combined in arriving at a judgment concerning mental health. This is particularly true for admissions to mental hospitals, legal judgments of insanity, exemption from military service for mental reasons, and in individual psychotherapy. Often, these criteria seem to indicate contradictory judgments in a particular case. The predominant value judgment in each situation determines which criterion is given the greatest weight.

For example, in deciding on the discharge of a sex-deviant, the weights assigned to the opinion of the psychiatrist, the tests of the psychologist, the feelings of the family and the reactions of the community, who will have to take the discharged person back, are not fixed. They depend on the power of

each factor. In one case, the view of the psychiatrist-in-charge will be decisive. In another, the family's influence with the hospital administrators may carry more weight.

Research in the mental health field might, therefore, proceed more effectively if the potential insights of each criterion are made use of. This is particularly true of cross-cultural studies. A frank recognition of the relativity of mental health will do much to improve both research and its application. It will reduce confusion by putting an end to the fruitless effort to arrive at a single criterion, which some scientists hope would be endowed through some magical process with the "objectivity" of temperature measured by a thermometer. Mental health cannot be reduced to such a single dimension. It is a value judgment, with all the potentialities for variation and change implicit in such a relativistic entity.

In a study of mental health, either of individuals or social groups, an examination can be made on the basis of each criterion. In extreme cases of either health or illness, the results are likely to be similar, regardless of the criterion used. In that much vaster mass of borderline cases, differences in final judgment derived from different criteria will focus attention on the social meanings by which mental health and illness are judged.[6] A multidimensional approach does not stand or fall by any single set of values. The use of multiple criteria, therefore, promises an advancement of knowledge beyond that achievable by a nonrelativistic approach.

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PSYCHOLOGICAL TESTS IN THE SELECTION AND PLACEMENT OF PSYCHIATRIC AIDES [1]

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It has been reasonably well established that the proper selection and placement of personnel in industry is an extremely important factor in its successful operation as well as in the mental health of its workers. While it was recognized that sound personnel procedures could detect obvious and sometimes subtle bases for qualifying or disqualifying an applicant or for making a judgment regarding job placement, it was nevertheless clear that even the best personnel procedures to date were subject to some error. One important purpose of psychological tests in industry has been to reduce these errors by supplementing other personnel selection and placement procedures.

While scientific approaches to the problem of selection and placement have been accepted in many industries, it is paradoxical to discover that mental hospitals have, for the most part, given little attention to the development of more scientific procedures for the selection and placement of their personnel(1). This is especially true for the largest single personnel group in the mental hospital—the psychiatric aides. As understanding of appropriate treatment and care of patients expands and deepens, the importance of these employees to a progressive mental hospital program is emphasized.

Rennie and Woodward stress that work "... in which one is interested and for which one is fitted supplies a very basic need and satisfaction"(4, p. 273). It is indeed remarkable that, although psychiatry has played an important role in developing this attitude on the part of industry, most psychiatric hospitals have made little attempt to understand how individuals engaged in work with psychiatric patients may receive and be assured of maximum personal and social satisfactions. While the authors of this paper recognize the fact that job satisfactions derive from many factors, it is their emphasis that proper selection and placement are of signal importance because these procedures should be the first step toward ensuring job satisfaction for the newly employed worker. Central to this problem is the fact that psychiatric aides adhere to the psychological laws of "individual differences"(5) and in this respect are not different from people engaged in any other kind of work. It is obvious that, if mental hospitals are to meet their responsibilities to the mentally ill, there must be a greater acceptance of responsibility for the adequate selection and placement of psychiatric aides, who are belatedly being recognized as the corner stone of sound treatment and care of mental patients. As Bonner has stated, "... one of the secrets of better mental hospitals in the future lies in the better selection and training of ward employees" (1, p. 669).

PURPOSE OF THE STUDY

The present investigators were concerned with the problem of whether psychological tests would contribute to an understanding of individual differences among psychiatric aides so as to aid in their selection and placement. Specifically, it was our purpose to determine if psychological tests could predict successful psychiatric aides and, conversely, to detect the unsuccessful ones.

PROCEDURE

The Revised Beta Examination(3) and the Multiple Choice Rorschach(2) were the psychological tests used in this study. The Revised Beta Examination is a group, nonverbal, paper-and-pencil intelligence test consisting of 6 subtests. The Multiple Choice Rorschach is an adaptation of the individual Rorschach and was devised for the purpose of group testing of personality.

[1] From the Connecticut State Hospital, Middletown.

Both of these tests were administered to small groups of psychiatric aides within a short time after they were employed at this hospital (1 to 2 weeks after employment). The number of subjects for this study were the first 113 unselected psychiatric aides employed after the study was undertaken. This group consisted of 61 men and 52 women with a mean age of 34.2 and an age range of 19 years to 70 years.

After 6 months on the job, these employees were rated by their supervisors on a rating scale specifically devised for this study (Fig. 1). After each subject was so rated his supervisor was interviewed in order to check on the validity of the ratings. In evaluating each rating scale for an over-all classification of the employee, the score for the entire scale was utilized as well as an inspection of the rating for each item in the scale. If a subject was no longer employed at the end of the 6-month period, he was also rated and additional information concerning his separation was procured.

On the basis of the supervisors' ratings and separation data, the subjects were classified into the following categories:

1. *"Good" and "Poor" Employees.*—All the psychiatric aides included were divided into 2 groups, *i.e.*, one group of 51 "poor" employees and one group of 62 "good" employees. These 2 groups were the basis of the first comparative analysis.

2. *"Definitely Good" and "Definitely Poor" Employees.*—Since it was felt that many "doubtful" employees may have been forced into the good and poor classifications, this first classification was re-evaluated as the next step in this study. This led to a further refinement between the groups by eliminating the doubtful good and the doubtful poor employees from this analysis.

Some employees had not worked a full 6 months for a variety of reasons. If they had achieved average ratings and there were no objections to their being re-employed, they had been included in the good group in the first analysis. However, for the second analysis, these employees were eliminated from the good group, justification for this being that the turnover of ward personnel was a serious administrative problem and by virtue of not holding their jobs for at least 6 months they could be considered undesirable employees.

Some employees had been rated good simply because they were employed for more than the 6-month period. These ratings were then reviewed with the supervisors who were asked the following questions: "Would you keep this employee if you were not short of help?" "Would you rehire this employee if he should ever be separated?" On the basis of the replies to these questions, several more employees were eliminated from the good group.

Finally, employees who had previously been considered good, but who required excessive supervision, were also removed from the good group.

On the basis of the above re-evaluation, a total of 40 subjects remained from the original group of 62 good employees. This group of 40 are referred to as the "definitely good" employees. The 22 subjects eliminated were not, however, placed in the poor group.

The poor group was also refined. Employees found to be alcoholics had at first been included in the poor group because of their single difficulty of not reporting for work after a drinking episode. These were eliminated from the poor group in this analysis since they were otherwise adequate in their job performance.

Several employees who were efficient and satisfactory workers, except that they had requested particular hours off and other individual scheduling arrangements, had been included in the poor group in the first analysis. These were eliminated from the poor group for the second analysis, since they had performed well on the job.

In all, 8 employees were eliminated from the poor group. From 51 subjects in the original poor group, the number was reduced to 43 and this group is designated "definitely poor." However, the eight subjects eliminated were not included in the good group.

3. *"Charge Attendant" Group.*—One final breakdown of subjects was made. The definitely good group was further refined into a "charge attendant" group to determine if such a group could be identified by test re-

Name: _____

Rated by: _____ Date: _____

1. *Industry*—degree to which the employee concentrates on and applies himself to his work.

1	3	5	7	9
Most energetic worker. Highest possible initiative.	Above average initiative and diligence, but not the highest degree.	Average application to work. Average initiative and diligence.	Below average attention to work. Poor initiative, but not the worst.	Most neglectful of duties. Laziest ever seen.

2. *Orderliness*—neatness of work.

9	7	5	3	1
Most slovenly and worthless work.	Below average neatness, but not the worst.	Average neatness.	Above average neatness but not the best.	Highest possible neatness.

3. *Cooperativeness*—ability to accept supervision and direction.

1	3	5	7	9
Most willing and cooperative worker.	Above average in readiness to work, but not most cooperative.	Average willingness to work and cooperate.	Below average willingness to work, but not most uncooperative.	Most resistive and antagonistic worker.

4. *Dependability*—in following instructions and completing assignments accurately.

9	7	5	3	1
Assignments never completed. Entirely unreliable and completely inaccurate.	Work below average in effectiveness and accuracy. Not worst.	Average accuracy and effectiveness in completing work.	Above average in completing work effectively. Not best nor most accurate.	Completes work most thoroughly and accurately.

5. *Reliability*—in attendance and punctuality (regardless of reasons).

1	3	5	7	9
Best possible attendance record. No absenteeism nor tardiness.	Better than average attendance record, but not best.	Average attendance and tardiness record.	Poor attendance record but not worst.	Completely unreliable in work attendance.

6. *Interest*—in welfare of the patients, attitude toward and treatment of them.

9	7	5	3	1
Most unconcerned and indifferent to patients' needs.	Below average concern for patients. Doubtful sincerity but not worst.	Average interest in caring for patients.	Above average concern for patients. Good rapport but not best.	Most sympathetic and understanding treatment of patients.

7. *Ability to Learn*—speed of grasping knowledge of duties and responsibilities of the job and application of this knowledge.

1	3	5	7	9
Quickest to learn. Best possible use of learned skills.	Above average speed in learning tasks and good use of skills. Not best.	Average in speed of learning tasks and in applying knowledge.	Below average in speed of learning duties but not worst.	Worst comprehension of and inability to grasp duties. Constant supervision required in application of knowledge.

8. *Personality*—whether suited for this type of work.

9	7	5	3	1
Most immature, negativistic, abrupt, and unpleasant.	Below average in tact, confidence, maturity, but not worst.	Average in friendliness, tact, confidence, and pleasant manners.	Above average in confidence, tact, manners, but not best.	Best possible combination of confidence, tact, maturity.

COMMENTS (For additional information):

FIG. 1.—Service rating of employee's job performance.

sults. This group was formed from the definitely good employees by taking only those who had achieved charge attendant status or those considered by supervisors to be suitable for promotion to charge attendant.

Statistical Treatment of Data

The test scores of the original good group were compared to those of the original poor group by preparing cumulative frequency tables that indicated the percentage of subjects achieving any given score. These tables were prepared for the total weighted scores, IQ scores, and subtest weighted scores on the Revised Beta Examination. For the Multiple Choice Rorschach, similar tables were prepared for the different types of pathological responses. These cumulative frequency tables were prepared for the good group and the poor group separately and were inspected for critical scores that would eliminate poor employees while retaining as many good employees as possible.

The next step in the analysis involved the preparation of similar tables for the purpose of deriving critical scores in the comparison of the definitely good group with the definitely poor group.

Lastly, the charge attendant group was compared in the same manner with the poor, the definitely poor, the good and definitely good groups to determine critical test scores that might help identify charge attendants among this psychiatric aide population.

Results

A comparison of the frequency distributions of test scores (cumulative frequency tables) of the original poor and good groups did not yield critical test scores that would help identify poor psychiatric aides.

The comparison of the charge attendant group with all other groups similarly did not yield critical test scores that would help in the selection of potentially superior psychiatric aides or charge attendants.

The analysis of test scores of the definitely good group and the definitely poor group, however, did yield useful critical test scores. Table 1 reveals that a total weighted score of 42 or below on the Revised Beta Examination eliminates eight of the definitely poor employees (19%) while not eliminating any of the definitely good employees. The use of IQ scores and the various subtest scores do not improve on these results.

After analysis of the various Multiple Choice Rorschach cumulative frequency tables, the most satisfactory results were derived from the use of the total number of underlined and checked poor form anatomical and X-ray responses. These are the responses that receive a score of 6 and 7 in the Multiple Choice Rorschach scoring system(2, p. 259). Table 2 reveals that 9 subjects of the definitely poor group (21%) checked or underlined a total of 22 or more of these specific pathological responses, as compared to only 2 subjects of the definitely good group (5%).

The test records of those eliminated by either of the above critical scores were checked and it was found that only one individual was identified as a definitely poor employee on both tests. Thus, a greater proportion of definitely poor psychiatric aides was being identified than was indicated by either critical test score alone. Using both scores, 16 subjects or 32% of the definitely poor group are identified, while only 2 subjects or 5% of the definitely good group are misidentified.

Discussion

The tests used in this study failed to differentiate between the good and poor employees apparently because the employees of borderline quality fused one group with the other. With the elimination of this borderline group and the classification of a definitely good group clearly demarcated from a definitely poor group, it was possible to identify a portion of the undesirable employees through the use of the psychological tests. It would thus seem that the tests used are not effective with marginal employees. Similarly, the charge attendant group could not be differentiated from any of the other groups, thus indicating that the present tests cannot be used to help in the selection of this highly qualified group. The reason for failure in the latter instance may be related to the possibility that the qualities entering into suc-

cess as a charge attendant may not be measured by the 2 tests used.

Total weighted scores on the Revised Beta Examination are more sensitive in discriminating between poor and good psychiatric aides than were IQ scores. This fact results from the difference between the nature of the weighted score as compared to the IQ score. The IQ is derived from the weighted score but is corrected for age. This allows for the normal decline in intellectual functioning that occurs with age(6) but, in so doing, yields an IQ that has meaning only in terms of an individual's own age group rather than the total working force of psychiatric aides, which covers a wide age range. Consequently, the inability of IQ scores to discriminate between good and poor employees indicates that age is a factor in the prediction of success in this particular vocation. The present paper is not concerned with this age factor, however.

Individuals identified as poor employees by the Revised Beta Examination were found to be different from the poor employees that were identified by the Multiple Choice Rorschach with the exception of one individual who received disqualifying scores on both tests. This finding demonstrates the necessity for utilizing a battery of psychological tests when dealing with selection and placement problems.

TABLE 1

CUMULATIVE FREQUENCIES OF REVISED BETA TOTAL WEIGHTED SCORES FOR DEFINITELY GOOD GROUP AND DEFINITELY POOR GROUP

Weighted total score	Definitely good group ($N = 40$)			Definitely poor group ($N = 43$)		
	f*	Cum f†	%‡	f*	Cum f†	%‡
84	1	40	100	..	..	..
82	..	..	..	1	43	100
80	..	..	..	1	42	98
78	2	39	98	1	41	95
76	2	37	93	3	40	93
74	2	35	88	1	37	86
72	..	..	..	2	36	84
70	2	33	83	2	34	79
68	3	31	78	2	32	75
66	3	28	70	1	30	70
64	2	25	63	4	29	68
62	3	23	58	4	25	58
60	4	20	50	1	21	49
58	2	16	40	2	20	47
56	7	14	35	1	18	42
54	2	7	18	4	17	40
52	..	..	..	..	..	..
50	2	5	13	2	13	30
48	1	3	8	2	11	26
46	1	2	5	..	..	..
44	1	1	3	1	9	21
42	..	..	..	3	8	19
40	..	..	..	..	..	..
38	..	..	..	2	5	12
36	..	..	..	..	..	..
34	..	..	..	..	..	..
32	..	..	..	1	3	7
30	..	..	..	..	..	..
28	..	..	..	..	..	..
26	..	..	..	..	..	..
24	..	..	..	1	2	5
22	..	..	..	..	..	..
20	..	..	..	..	..	..
18	..	..	..	1	1	2

* f refers to the number of subjects receiving the given score.
† Cum f refers to the number of subjects receiving scores up to and including the given score.
‡ % refers to the percentage of subjects receiving scores up to and including the given score.

Psychological tests in and of themselves can never be the final and complete answer to all employment problems. In this particular study, all the subjects had been selected by the usual hospital personnel procedures as potentially satisfactory psychiatric aides. Within 6 months, 51 of the 113 employees were found to be unsatisfactory. This is 45% of the psychiatric aides employed during the period of this study. Psychological tests were capable of identifying 32% of those employees eventually recognized to be unsatisfactory by actual work performance, while misidentifying only 5% of the satisfactory employees. This is obviously a significant degree of improvement over the usual personnel selection procedures and compares favorably with much of the results in industry. The percentage of successful identifications of poor employees would probably have

TABLE 2

CUMULATIVE FREQUENCIES OF TOTAL NUMBER OF POOR FORM ANATOMICAL RESPONSES AND X-RAY RESPONSES ON THE MULTIPLE CHOICE RORSCHACH FOR DEFINITELY GOOD GROUP AND DEFINITELY POOR GROUP

Number of responses	Definitely good group ($N = 40$)			Definitely poor group ($N = 43$)		
	f*	Cum f†	%‡	f*	Cum f†	%‡
0	..	..	..	2	43	100
1	..	..	..	3	41	95
2	2	40	100	2	38	88
3	5	38	95	3	36	84
4	2	33	83	4	33	77
5	2	31	78	5	29	68
6	..	..	..	4	24	56
7	3	29	73	..	..	..
8	4	26	65	2	20	47
9	3	22	55	2	18	42
10	3	19	48	..	..	..
11	3	16	40	2	16	37
12	1	13	33	..	..	..
13	2	12	30	1	14	33
14	..	..	..	..	..	..
15	..	..	..	..	..	..
16	2	10	25	1	13	30
17	2	8	20	..	..	..
18	..	..	..	..	..	..
19	1	6	15	1	12	28
20	2	5	13	2	11	26
21	1	3	8	..	..	..
22	..	..	..	1	9	21
23	..	..	..	1	8	19
24	..	..	..	2	7	16
25	..	..	..	1	5	12
26	..	..	..	1	4	9
27	..	..	..	1	3	7
28	1	2	5	1	2	5
29	..	..	..	..	..	..
30	1	1	3	..	..	..
31	..	..	..	..	..	..
32	..	..	..	..	..	..
33	..	..	..	..	..	..
34	..	..	..	..	..	..
35	..	..	..	..	..	..
36	..	..	..	..	..	..
37	..	..	..	..	..	..
38	..	..	..	..	..	..
39	..	..	..	..	..	..
40	..	..	..	1	1	2

* f refers to the number of subjects receiving the given score.
† Cum f refers to the number of subjects receiving scores above and including the given score.
‡ % refers to the percentage of subjects receiving scores above and including the given score.

been higher if the results of the tests had not been made available to the head of the nursing department, who used this knowledge in the ward placement of these personnel.

Probably other psychological tests measuring other areas of human behavior might improve upon this percentage of prediction. Among such tests might be verbal tests of intelligence since the psychiatric aide performs tasks that are commonly considered to require verbal ability. Other tests that might be utilized are those that would specifically screen employees with psychopathic personalities. This group constitutes the greatest single problem in the psychiatric aide population.

While this paper may have unduly stressed the importance of selection because of the nature of the study, it should again be emphasized that the results of the tests have been used by the head of the nursing department to guide her in the appropriate ward placement of each psychiatric aide. It has been her judgment and that of her assistants that the use of these tests for placement purposes has been of invaluable help. To the authors, the use of tests as a basis for correct ward placement is probably as important, if not more so, than their use in selection of psychiatric aides.

Summary

This paper describes the utilization of 2 psychological tests (Revised Beta Examination and Multiple Choice Rorschach) in the prediction of successful psychiatric aides. Psychiatric aides, 113 in number, were first classified into good and poor employees. Psychological tests were unsuccessful in discriminating between these 2 groups. However, when these 2 groups were refined into a definitely good group and a definitely poor group by eliminating marginal employees, psychological tests selected 32% of these very poor employees while only 5% of the very good employees were falsely identified. An attempt was also made to identify the charge attendant group but this was unsuccessful. Present findings indicate that further research utilizing a more extensive battery of psychological tests should lead to even more fruitful results in the problem of selection and placement of psychiatric aides.

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THE CONVERSION OF PASSIVITY INTO NORMAL SELF-ASSERTION [1]

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This paper reports a procedure in the treatment of the patient in whom passivity is a major problem. By passivity is meant behavior such as the habitual reaction to hostile activity on the part of others by non-assertion, by avoidance of the situation, and by conversion of his natural self-assertion into anxiety and possibly into self-criticism.

The patient whose constant response to hostility in others is by passivity seeks to avoid quarrels, to avoid anything that will lose him the esteem and affection of others. In consequence of this, he does not maintain a firm position on any issue. He has a series of rationalizations, such as, "fighting never gets you anywhere," "there are always two sides to any question," and "who am I to judge," "I never like to hurt other people's feelings."

In consequence of this inability to express his natural self-assertion and anger, he may suffer from considerable covert resentment about which he feels guilty, or he may succeed in repressing it entirely. He cannot readily get over slights, and is an unusually sensitive person. As his passivity becomes more extensive, and as he suppresses and represses his hostility in greater measure, his general behavior becomes less and less adequate. He cannot make decisions; he cannot take responsibilities; his anxiety and feelings of guilt increase and frequently are accompanied by psychosomatic symptoms, which in our experience do not necessarily depend upon the psychodynamic situation that has led to his passivity, but upon his habitual response to stress, and this we have found to be a composite of constitutional and experiential factors.

Under ordinary circumstances, the treatment of such an individual by the usual non-directive procedures is apt to be long and difficult. Passivity as a pattern of response is ordinarily set up in the earliest years of childhood, although we have, on occasion, seen it take form in adolescence. Moreover, passivity, as a way of life, is supported by many sanctions in our society (1), so that the individual is at no loss to find rationalizations for its continuance.

From observation over the last several years of the processes of reorganization under psychotherapy, we have noted that when the figure originally responsible for the patient's passivity has been identified, and when the patient succeeds in asserting himself with that figure, the whole pattern of his passivity rapidly breaks up. It is true that there may be secondary figures who have acquired a meaning in their own right, and who have to be dealt with separately, but, in general, where the patient has succeeded in changing his pattern from passivity to normal self-assertion with the key figure, his passivity is quite rapidly abandoned.

Based on these observations, a technique has been worked out to facilitate this progression of events. This report is derived from 9 cases in which this procedure has been used.

In brief it consists in 4 phases: (1) recognition by the patient of his hostility and of the key figure in its production, (2) preparation of the patient for assertion against the key figure, (3) phase of assertion, and (4) management of postencounter period. These will be described in some detail.

1. *Recognition of the Key Figure.*—The recognition by the patient of his hostility is not ordinarily difficult, although it may take time until the full range of its manifestations can be worked out. There may be more trouble, however, in identifying the key figure, since that figure may be screened by some other individual.

2. *Preparation of the Patient for Self-Assertion.*—This is considerably more difficult, because of the extensive integration that the existing pattern of passivity has acquired throughout the patient's life, because of his intense fear of loss of affection, and because our culture offers him various ra-

[1] Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

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tionalizations that serve to sanction the passive way of life.

There are, however, powerful forces upon which we may depend. First, there is the basic drive for normalization(3, 2). Second, there is inherent in the individual a fundamental need to control his environment(2).

Hence, it is usually possible, fairly soon after the identification of the key figure, to have the patient begin to assert himself in fantasy, then in role playing with the therapist, and finally in reality with a series of secondary figures. The assertion in role playing ordinarily is directed toward the primary figure, but may also be directed toward secondary or substitute figures.

Along with this should be carried on a continuous evaluation of the patient's passive pattern in dealing with day-to-day events and in working out with him an alternative to this. The patient is urged to attempt a more assertive method of managing his dealings with people in stores, at parties, and in general with a great range of individuals. Together with this should go a strengthening of a positive patient-therapist relationship, designed to give the patient support during the period of preparation, and during the period of actual dealing with the primary figure.

It is to be understood that during this period, especially as time for direct assertion with the key figure approaches, a considerable number of resistances and rationalizations will appear. Among these are the assertion that the patient "is not going to benefit himself at the expense of making someone else unhappy," that "mother wouldn't listen anyway," that "she is an old woman," that "everyone will be mad with him if he says anything to her," or "wouldn't it be just as good if he wrote it in a letter, or said what he thought to his father, who could then pass it on to his mother."

3. *Phase of Assertion.*—The actual encounter between the patient and the primary hostility-evoking figure must be on a face-to-face basis. For the encounter to be successful, it is most desirable (a) that the expression of hostility be as complete as possible, *i.e.*, that the patient should be able to feel his resentment during his attempted self-assertion, (b) that at least the major experiences that have caused his hostility be brought out and re-activated, and (c) (of lesser importance) that the hostility-evoking figure should be forced into subordination during the interview.

The matter of experiencing feelings of hostility, as well as a feeling of freedom to assert oneself, is of importance in view of the fact that the main objective of this procedure is to set up a new pattern of reaction with respect to the key figure. Emphasis should be placed upon this matter of feeling hostility, since, as is well known, a common form of defence against one's own hostility is to recognize the situation that is evoking it, but to repress the feelings that the situation evokes.

The second condition, namely, that during the encounter the major hostility-evoking situations should be stated, and thus relived, is also cardinal. If some are omitted, then there will remain between the patient and the key figure certain types of situation in which the patient will continue to react in terms of subordination and passivity, not only to the key figure, but also to all substitute figures. Hence it frequently is necessary to instruct the patient that more than one interview with the key figure may be necessary.

The third condition is of lesser importance, since during the encounter, if successful, the patient is considerably more concerned with his own reactions and the building up of a new pattern of self-assertion than he is with the key figure's reactions. But some patients have felt dissatisfied and frustrated where the key figure simply agreed with their accusations in a spirit of "I will say or do anything that will be of help to you in your struggle for recovery."

4. *Postencounter Phase.*—The effects are both immediate and continued. The immediate effect of a successful encounter with the key figure is a feeling of freedom and confidence and increased power. There usually is a marked decrease in the feeling of hostility toward the key figure; this spreads rapidly to all substitute figures, so that the individual is able to enter into much more satisfying relations with others.

This latter development is progressive, and the individual may show a considerable range of changes in behavior, with respect to all

those things that arose not from his general needs but from his repressed hostility toward, and his subordination to, the key figure. Hence there may be changes in job interest, in general dealings with women, in dressing, as well as in his day-to-day manner. The relations with the key figure also may undergo progressive as well as immediate change, usually in the direction of an increasing indifference, sometimes in the direction of acceptance of the key figure, who no longer is seen as a threat but may be conceptualized as an adequate and, at all events, subordinate person.

These effects—the increased confidence, the expanded capacity for normal self-assertion, the changes in neurotically determined patterns of living—are gradually incorporated into the patient's day-to-day pattern of living through a process of learning. He learns socially accepted ways of expressing his self-assertion. During the period immediately following upon his encounter with the key figure, the patient's self-assertions are apt to be crude, damaging, and counter-hostility-provoking. This is so because, first, there has been so great an accumulation of long-repressed hostility; second, he has had little or no practice in expressing self-assertion in any form, whether socially acceptable or not. It is of interest, with respect to theories of joking, that many patients, during this transition period, find it easiest to express their resentments in the form of apparent kidding and joking with the objects of their hostility, and then gradually settle down to a more matter-of-fact firmness in asserting their rights and a friendly forthrightness in maintaining their opinions.

Typical Cases

The first case is that of a 56-year-old woman who has had an exceedingly long history of passivity in her relations with others, coupled with anxiety, depression, and a great range of hypochondriacal complaints that have resulted in numerous operations.

There was great anxiety concerning her hostile and sexual impulses, which were strongly repressed. An important figure in the genesis of her hostility was her mother, who had given all her affection to her older daughter and son and, moreover, had failed to protect the patient from a brutal father. The mother, though now financially dependent on the patient, was continuing to give her affection and admiration to the 2 older siblings. By the time the patient came for treatment she was aware of her hostility, although still unable to express it to her mother. To visit her mother, and hear her praise her son and other daughter, the patient declared, made her sick.

After preparation lasting about a month, during which the patient resisted asserting herself openly to her mother, on the grounds that her mother was "an old lady now" or that "she could never understand" or that "after all, she is my mother," she finally faced her. She told her mother that she had been bitterly unfair all her life, and that the patient actively resented this. She felt greatly improved almost at once after this encounter. Her mother's favoritism no longer seemed to matter, and since then she has been able to treat the mother as an old lady, and no longer as a threatening figure. The mother herself has changed her rôle and has become more dependent on the patient, more aware of her support and strength. These changes have improved the patient's relations with others, so that, in place of a retiring, self-blaming individual, she is now recognized as being self-reliant and able to take care of her own interests.

A second case illustrates the occasional need to deal with secondary figures that have acquired meaning in their own right. The patient is a young married woman who was brought up in a most repressive setting in which there was continual conflict between the parents. The mother was a rigid, inhibited woman who manœuvred the patient into alliance against her husband and an older sister. The patient longed to be accepted by her father, but found herself continually labeled as "mother's girl," and out of sheer self-protection in the family feuding often was forced to side with her mother, though always unwillingly. Her only feelings toward the mother were resentment and guilt.

After a long period of psychotherapy, in which no attempt was made to have her confront her mother, she did so spontaneously and felt considerable relief.

Her marriage later, however, brought her into contact with her mother-in-law, who was aggressively determined to hold on to her son and who, moreover, attempted insidiously to wean the patient's children from her. The patient resented this deeply and many of her old symptoms of anxiety and hostility returned. She undertook further psychotherapy and was prepared specifically to assert herself with the mother-in-law. Preparation was rapid, the self-assertion was relatively easy, and the results have been quite complete. The patient no longer is disturbed by her mother-in-law's manœuvres and can tolerate the latter's antagonism to her with equanimity.

A third case illustrates a failure, due to the assertion having been made without adequate preparation. This 42-year-old woman had been the youngest child in a singularly disorganized family; the mother had had a temper feared by all the family members. There were frequent scenes of violence. During the first 10 or 11 years, the

mother made the patient her favorite, getting her to spy on the father, but failing to protect her either from the father or from the teasing and actual tormenting to which her older brother and sisters subjected her.

From her twelfth year onward, the patient tried quite vainly to assert herself with her mother, whom she now hated; she never succeeded and sought her defences in various rationalizations, such as, that "it is no use quarreling," "I never want to be a loud-mouthed, angry person like mother."

She developed a severe anxiety neurosis with a great array of psychoneurotic symptoms. In psychotherapy she blocked continually; she could not bring herself to discuss many areas of her life and protected herself by lying on occasion. It was only after a year that she was able to discuss the full range of her experiences with her mother.

We commenced preparing her to assert herself with her mother, but before this was accomplished the patient, who was strongly indoctrinated with the heroic-romantic way of life and believed that what had to be done had to be done, and that to be afraid was to be "yellow," tackled her mother on her own. The attempt ended in failure, the patient could not stand her mother's counter-reaction, and the scene ended by the patient's buying her a handbag.

Despite efforts extending over 6 months, it has never been possible to get this patient to attempt to assert herself with her mother again. Her symptoms have continued and, indeed, are accentuated.

Results

Of the 9 cases dealt with by this procedure during the last 2 years, 6 can be regarded as fully successful. These patients have achieved a most significant gain, and achieved it within a period of time that would have been impossible if the ordinary processes of reliving and gradual desensitization had been carried out.

Moreover, in all 6 cases, relations have been maintained with the key figures. These relations are mature, in place of the earlier relations, which were primarily those of the subordinated child. There is no indication that the encounter had any lasting traumatic effects upon the key figures.

Of the remaining three, one can be dismissed, insofar that despite 4 months' work it has been impossible, because of her anxiety, to prepare her for an encounter with the key figure, in her case the father.

The second patient had an incomplete encounter, following upon which she manifested intense resentment against the therapist for about 6 weeks, accusing him of depriving her of a relationship that was essential to her. This has subsided, however, and she is prepared now more effectively to meet and assert herself with the key figure a second time.

The third patient already has been mentioned. Here the encounter was premature and left the patient quite unable to face the matter a second time.

Theory

How does this procedure work? Our knowledge is still quite limited. We may start from certain well-accepted premises: first, that one of the basic trends of the human organism is toward normalization; hence there is a constant drive on the part of repressed, intensified action tendencies toward expression and desensitization in consciousness. Second, one may state that a no less basic trend is toward the extension of the individual's control over his intra-organismal relations and his relations with his environment. Hence, we may anticipate that passivity, in most cases, is a state of most uneasy equilibrium and one that can be maintained only by neurotic necessity.

We may say next that individuals who seek help are, for the most part, those in whom passivity is already breaking down. If repression is strong and adequate, then there will be no symptoms or discomforts requiring the psychiatrist's care. Once such a patient has entered therapy, he acquires additional motivation in the development of a positive patient-therapist relationship.

The theories of desensitization and of the management of defenses require no elaboration. But a matter of prime theoretic interest is how the encounter scene serves to establish a new pattern. Here one must look to learning theory for guidance and state that we now recognize the possibility of single trial learning(4). The reinforcement is to be seen in the considerable gains to the patient in achieving his basic need for more extended control. These gains are repeated as his control expands.

The fact that some patients require repeated encounters before the new pattern is firmly established is also suggestive. The quite extensive reorganization of patterns of

behavior in secondary situations that occur after the encounter may be seen as taking place on the basis of economy; now that there no longer is any need to give expression to the neurotic mechanisms, unless they have acquired secondary meaning, they give way to the normal needs of the individual.

Summary

A technique for the more rapid and effective conversion of passivity into normal self-assertion has been presented. Where carefully followed out, it has proved successful in a satisfactory percentage of cases.

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THE ROLE OF THE GENERAL HOSPITAL IN THE CARE OF THE MENTALLY ILL

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My reason for presenting the subject of the treatment of psychiatric cases in general hospitals is to better acquaint those of you who have not had experience in this type of care of the mentally ill. I will attempt to show you how the individual, the family, the hospital, the community, and the state will profit by the inclusion of such a unit.

The care of the mentally sick in a general hospital dates back to 1756 when the Pennsylvania Hospital in Philadelphia was opened. In this general hospital there was a department for the "care and treatment of lunaticks." Until very recent years, however, few general hospitals have established separate departments for the handling of the psychiatric problems arising in that hospital and in the community. Virginia at present has two hospitals offering this service; one at the University of Virginia and the other at the Medical College of Virginia, in Richmond. In 1908 the New York Hospital made provision for psychiatric patients by including a separate department and building, in its facilities.

In 1939 there were only 37 general hospitals in the United States with psychiatric facilities, with an additional 6 Veterans Administration Hospitals having this type of service. Today there are 131 such hospitals, not all, however, with separate units.

The problem of caring for the mentally ill is not wholly a state responsibility—the locality should bear its share of the load. In doing so it should provide facilities for the care and treatment of the neurotic and psychotic individual in every general hospital of any size. A general hospital, to be worthy of the name, should be prepared to treat every type of illness.

Establishment of these units in general hospitals is often opposed by certain doctors and not infrequently by lay governing boards because they do not understand the nature of the work or the great amount of good that can be accomplished.

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The limited bed space in most of these units restricts their usefulness. There is usually a waiting list for admission and referring physicians are often irked because they cannot get a patient admitted the day they apply —we have had some suicides reported, by referring doctors, while a depressed patient was waiting to be admitted; on the other hand, some patients have reportedly recovered while waiting!

Until a relatively short while ago psychiatry was limited to institutional practice, but now it has become of importance in the broad field of medical science. Psychiatry is now being recognized almost everywhere as an integral part of medicine, and the work of the psychiatrist has been extended into all branches of medicine.

The organization of a psychiatric department in a general hospital should be well planned, both from a physical and a personnel standpoint. The size of the professional personnel, of course, should depend on the number of beds. There should be a senior psychiatrist, or director, who in a teaching hospital usually is the professor or chairman of the department. He may be full-time or part-time, and the number of assistant psychiatrists should depend upon the number of beds, allowing an additional assistant if the senior psychiatrist is part-time. There should be one senior resident and an assistant resident to each 25 patients. There should also be 2 rotating interns for at least 2 months' service each, and all medical residents should rotate through the psychiatric service. Fellows in graduate training and in research are of great value in the over-all care of the patient as well as in teaching.

The following additional personnel is suggested as desirable for a 50-bed unit in a teaching institution: a supervisor-nurse, one graduate psychiatrically trained nurse for each 15 patients for each shift of the 24 hours; at least 20 student nurses; 1 female attendant for each 8-hour shift and 2 orderlies or male attendants for each 8-hour period of the day. In our department we use

medical students as night orderlies and attendants. This has proved most satisfactory and a few senior medical students are very successfully employed as externs. These men have all shown an interest in psychiatry and they willingly take their senior elective in this branch of medicine.

A psychiatric unit in a general hospital may be advantageous in many ways. For one thing, it may be of considerable value to the medical and nursing students. In my opinion no medical student should be graduated without having taken a course in the psychiatric aspects of a general hospital practice. It has likewise been emphasized that psychiatry should be taught to medical and nursing students not because of the percentage of the patients who are psychotic but because approximately 60% of the symptoms presented by all patients will require understanding in this field. When the hospital accepts an intern it assumes a definite duty as to the education of that individual, which it cannot properly discharge unless it provides him with an opportunity to understand and intelligently treat many of the psychiatric problems.

It has been my observation that the interest in psychiatry of the student nurse, the medical student, and also the intern has been materially increased since we have had adequate teaching material and since the department has been properly operated for instruction in this subject. On the other hand, psychiatry has profited considerably by being included in the activities of a general hospital. Also, it has become clear to the skeptics in other branches of medicine that they and their patients can profit by the early recognition and treatment of psychiatric disorders. It can be demonstrated that psychiatry is not the sterile subject that it once was, and as many in other specialties of medicine and surgery still believe it to be. Many of our modern therapeutic methods have proved of great value.

It is an irrefutable fact that psychiatric services in general hospitals have been of inestimable value in uncovering neurotic and psychotic conditions in patients that are retarding convalescence from other medical and surgical experiences. Treatment of these conditions has hastened the over-all recovery. Furthermore, psychiatric services have made for the better understanding of mental disorders by physicians on the other services and the presence of the mentally ill in the hospital tends to make the public, doctors, and nurses as a whole accept these patients as being ill.

The psychiatric ward in general hospitals is a break between the patient's home and a mental institution. At least 80% of admissions are discharged to their homes as having made some improvement, and most of these have made a social recovery. Many of these persons might otherwise have been committed to a mental institution; therefore, it can be seen that early treatment is helping to lighten the load on state institutions. This type of psychiatric unit should be able to take legally committed individuals. This, however, is seldom necessary. At the Medical College of Virginia, for example, of our 707 admissions in 1949 only 15 were legally committed.

The psychiatric unit may and does render service to the other sections of the hospital and to the community in that it is equipped to handle mildly or severely disturbed mental patients who cannot be adequately treated on the medical and surgical floors of the hospital or in the private home. Such a unit may also obviate the necessity for the confinement in jails of many mentally ill while they are awaiting transfer to a state hospital. It also may be of assistance to the courts in deciding the competency of an individual before trial.

The cost of hospitalization is appalling to the families of many mental patients; but the families of a patient with tuberculosis, with heart disease, or with an orthopedic ailment seldom seem to marvel at the long hospital stay necessary for these chronic illnesses, and they apparently are quite willing to make any sacrifices to take care of the financial burden of hospitalization. But this is not so likely to be true of the families of individuals suffering nervous and mental disease. The modern treatment of psychiatric cases has rendered hospital stay much shorter than once was the case. Our average patient stay in the hospital last year was 24 days.

Some doctors believe that isolation and segregation of psychiatric patients is unnecessary. However, we do not subscribe to

that contention. Before we had a psychiatric unit in our hospital we found it very difficult to care for any but the very mildest cases, and they were not always managed to our satisfaction. If the physical setup of the psychiatric unit is good, any type of mentally ill patient can be taken care of and properly segregated according to the degree and character of mental disturbance.

It is rather disconcerting to hear visitors to other parts of the hospital as well as physicians—and not always those of junior grade—make wisecracks about the psychiatric section as the "nut ward." This attitude on the part of the nonpsychiatrically oriented doctor is unwholesome and does not tend to help in the over-all understanding of nonmedical individuals. However, I believe that this attitude is improving now that hospital personnel are seeing for themselves the value of the psychiatric unit.

The nurses and doctors often discuss the question of the "stigma" of mental illness with laymen, and I regret to note that some of them make no effort to overcome the belief that there is such a stigma. For we must remember that it is this so-called "stigma" that in the past has permitted the neglect of proper treatment of so many cases and has allowed them to become chronic.

Patients and their families seem to feel that there is less "stigma" in going to a psychiatric section of a general hospital than there is in going to a mental hospital or sanitarium. It is also much easier to persuade a patient and his family to go to the psychiatric division of a general hospital than to one that is generally known to receive only mental patients.

Of necessity, the study of a mental case in a general hospital must be rapid and thorough. Psychiatry is intimately concerned in every disturbance that the human body is heir to, whether it be anatomical, physiological, or psychological. We must determine not only how a person behaves but, if possible, why he behaves as he does. We must also learn whether the condition is largely the organic reaction type of psychiatric disorder or whether the condition is a psychobiological one.

A frequent objection to psychiatric patients is that they are noisy. I dare say that there is less noise on the average well-ordered psychiatric unit in a general hospital than there is in a medical or surgical ward. Occasionally overactive, maniacal, or delirious patients will be disturbing for a time, but most often they are quieted within a few hours—and usually without the use of drugs.

A question frequently raised is, in what way are we able to hold a mentally sick person against his will. With a few exceptions, our patients have been voluntary. Some of them object to the so-called confinement and the necessity for the occasional locking of a door, but most of them are soon contented and cooperative. Occasionally a disgruntled patient will demand his release, and this is given when reliable persons will assume the responsibility for the released patient.

It is desirable that each psychiatric unit have an ambulatory outpatient department. Certain patients can be followed with advantage for psychotherapy as outpatients after discharge from the hospital. In our ambulatory clinic we had a total of 2,823 visits last year. This outpatient department is an excellent training ground for medical students and house staff, all of whom are required to spend a certain amount of their time in this field. A child guidance clinic was put in operation early this year and is an integral part of the outpatient psychiatric division.

A well-ordered and functioning occupational therapy department is essential for the successful treatment of neuropsychiatric patients. The insistence of some occupational therapy workers on assigning a task to each patient regardless of his interest seems to me to be a bad practice. A patient should be counseled and encouraged, and his interest should be aroused in a certain task, but he should not be forced. A woman who might not like to make baskets or rugs might be very happy to do ceramics, or to paint, or to do leather or metal work. Some cannot be interested in work but are avid for games, group singing, or other recreation. I, personally, do not think that occupational therapy and recreational therapy can be separated. Many visitors marvel at what a good time our convalescent patients appear to have. No greater compliment could be paid the

service, for we do strive to keep them busy and contented.

A department of psychology is also essential to the proper functioning of a well organized psychiatric unit. The psychologists can be of valuable help, not only in mental testing but under proper supervision and control in doing some of the therapy. Psychiatric social workers may likewise be helpful in this type of organization, just as in the conventional mental hospital.

Such physical therapeutic procedures as insulin shock, electroconvulsive therapy, as well as drug hypnosis and psychosurgery, have been distinctive factors in the growth and usefulness of psychiatric units in general hospitals, as these measures will certainly shorten the hospital stay of acute remediable types of mental diseases.

Electroencephalography is an important and useful aid in diagnosing certain mental and nervous disorders and should be a part of the equipment.

We give a limited number of electric shock treatments to outpatients, but never, I believe, have we given this type of treatment to a patient who has not previously had it in the hospital.

In view of the personal and confidential nature of case histories in any psychiatric organization, these records should be kept from the gaze of the curious. Those in charge of record rooms of general hospitals have in certain instances insisted that these records be kept in the general record room, but I have opposed this on the ground that there are many hospital employees with curiosity other than scientific and that many of these might get access to, and not hesitate to divulge, these personal confidences contained in the histories.

In one of the oldest psychiatric divisions in a general hospital in this country, they have never used locked doors or secured windows. It is a rich hospital and there must be abundant nursing and attendant personnel to look after these patients, which must be the reason that they do not have more suicides and escapes than they do. It seems to me necessary that all windows be covered with patented screens and that certain doors must be locked at times. We strive diligently to give the patient every freedom consistent with safety and good therapy, and we make a conscious effort to have as few locked doors as possible.

It is contended by many medical men, and occasionally by a psychiatrist, that the department of psychiatry should be developed in the department of medicine. There is no question but that there should be excellent cooperation by the department of psychiatry with the other branches of medicine and surgery, as a specialty closely allied with the others. But psychiatry is an entity and should be on its own.

As has been stated, many of the 100,000 individuals admitted to the state hospitals in this nation each year are a result of neglect due to the lack of proper early treatment. If all general hospitals were to provide proper study and care for the psychiatric case many of these persons would never get to the state hospitals.

The creation of psychiatric care in general hospitals brings benefits not alone to the hospital but to the community, the medical profession, and to the patient himself. The hospital becomes *general* in reality, it raises the level of medical practice, it gains economically and saves money for everyone concerned. It discharges a duty it owes to the student nurse and to the medical house staff. The patient is benefited by being able to receive treatment near his home. When psychiatry is closely associated with its brothers—medicine and surgery—the old ideas of "insanity," "lunatics," and "crazy" people, to a growing extent, will be done away with by demonstrating to all that the mentally ill patient can be studied and treated as scientifically and as well as those with other types of illnesses.

ATROPINE TOXICITY IN THE TREATMENT OF MENTAL DISEASE[1]

GORDON R. FORRER, M. D., YPSILANTI, MICH.

An investigation of the effects of repeated periods of atropine toxicity on a small group of schizophrenic patients, conducted by the author(1), was followed by a more extensive study.

We report here 183 unselected cases of mentally ill patients who were administered repeated toxic doses of atropine sulfate by intramuscular injection. Patients were treated 3 to 6 times per week for 3 to 60 treatments with a dosage of 32 mgms. of atropine sulfate per treatment. This dosage level was selected after much experimentation with both smaller and larger amounts. Our aim was to produce repeated periods of temporary psychic dysfunction.

The ages of patients ranged from 14 to 70 years. There were 100 women and 83 men in the series. A total of 3,456 treatments was administered. Posttreatment evaluations were based on the patient's condition 1 week and 5 to 6 months following cessation of therapy.

Atropine is a racemic mixture of the optical isomers of hyoscyamine in equal parts. Most of the potency of the drug is due to the levorotatory isomer(2). Atropine acts as a parasympathetic depressant by blocking the action of acetylcholine and experimentally exerts some blocking effect on autonomic ganglia. Peripherally, the most important action is on smooth muscles and secretory glands innervated by postganglionic cholinergic nerves(3).

Overactivity of the sympathoadrenal system is simulated because normal adrenergic impulses dominate following the block of cholinergic nerves. Peripherally there is mydriasis and cycloplegia, inhibition of respiratory secretions, relaxation of the peribronchiolar musculature, cardiac acceleration, inhibition of sweating, decrease in tone and peristalsis, and increase of sphincter tone in the gastrointestinal tract.

The central effects of atropine toxicity, the restlessness, delirium, delusions, hallucinations, and coma are well known, but the mechanism of this central action has not been determined.

It is interesting to note, in this connection, that Mann, Tennenbaum, and Quastel(4) have demonstrated that nervous tissue alone was capable of synthesizing acetylcholine in vitro and Chute(5) and associates observed that acetylcholine was released into the perfusion fluid flowing through the isolated cat brain. Miller(6) and co-workers studied the effect of eserine and acetylcholine when locally applied to the cortex of cats. They found that atropinization abolished the electrocorticogram spikes induced by these drugs. These findings suggest that the blocking of the acetylcholine utilization by atropine is partially responsible for the central effects of the drug.

Veit and Vogt(7) using 4 to 20 mgms. of atropine sulfate per kilo in cats and dogs were able to show that the highest concentration of the drug is found in the cerebral and cerebellar cortices, the caudate nuclei and midbrain with appreciable, but smaller, concentrations elsewhere.

The lethal dose of atropine is not known. No reference to death occurring in an adult owing to toxicity could be found in the literature. The largest ingested amount with recovery on record is one gram. Goodman and Gillman place the lethal dose in the range of 100 mgms. of the drug. They state that it is one of the safest of the potent alkaloids.

An observation by Donnadieu(8) that customary doses of atropine administered to a catatonic schizophrene who exhibited vagotonia resulted in remission of his illness suggested that the autonomic changes occurring as a result of atropine sulfate administration might be therapeutically beneficial in mental disease. We investigated this possibility by treating 60 additional unselected mentally ill patients with daily doses of 1 mgm. of atropine sulfate intramuscularly. Each patient received a total of 40 treatments with this dose. Two patients of this group showed

[1] Read at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

very slight improvement; 58 showed no change in their mental status following the termination of treatment. We conclude from this that no improvement in mental condition is to be anticipated from the daily administration of atropine sulfate in customary amounts.

It has been repeatedly observed that mentally ill patients occasionally recover from their psychoses following a severe illness. It was felt that perhaps temporary psychic dysfunction due to toxicity, occasionally accompanying severe illness, was associated with the reintegration of the ego.

Of the 183 patients administered pharmacotoxic therapy with atropine sulfate, 25 received subsequent electroconvulsive therapy, 3 could not be followed, and 1 died. The statistical analysis is presented on 154 patients who received no subsequent form of therapy. All patients were state hospital residents. They were classified into diagnostic categories on the basis of the initial diagnostic impression, or by staff diagnosis where this had been made. It became evident that many patients had regressed before atropine toxicity therapy was initiated, but no attempts were made to correct this factor. Of the 154 patients, 43 had been overtly psychotic for less than 1 year, 32 had been overtly psychotic between 1 and 2 years, and 79 had been psychotic for more than 2 years.

Procedure.—Patients were confined to bed on treatment day. Therapy was carried out in a cool, quiet, partially darkened room with groups of approximately 20 patients. One trained nurse and 2 ward attendants were in the treatment room during the period of toxicity estimating temperature by touch, recording pulse, blood pressure, and respirations every hour. The drug was administered into the deltoid region by intramuscular injection one hour after breakfast. Two percent pilocarpine eye drops were administered every hour for 8 hours on treatment days to forestall the possible complication of glaucoma. Glycerine was applied to the lips every hour. Temperature was not determined by thermometer, primarily because it was felt that rectal temperatures would be unwise to attempt in patients whose basic conflicts were of a sexual nature. Temperature was estimated by hand contact and alcohol sponges were used freely in those patients who seemed "warm." Occasionally, sodium amytal up to 0.5 gram was given intramuscularly if restlessness seemed unduly marked. Sporadic nausea and vomiting were satisfactorily controlled by administering small sips of water. The noon meal was omitted.

Effects of Atropine Toxicity.—Drying of the mucous membranes of the mouth was prominent and caused much complaint from this group of patients. No respiratory depression, nor heart block, was observed. Two patients, already hypertensive, showed marked increase in blood pressure during toxic periods, but there was no constant pattern of blood pressure fluctuation in the individual nor in the group. Almost invariably there was some blood pressure fluctuation during each toxic session. Tachycardia with pulse rates of 120 to 160 per minute persisted for 2 to 3 hours.

Electrocardiograms obtained on 7 patients during the height of toxicity revealed no significant abnormalities. Electroencephalograms obtained before and during periods of atropine toxicity on 9 patients revealed an increase in voltage and a decrease in frequency during toxicity. Hyperactivity and panic reaction were unusual, only 5 having been observed in this series. Restlessness was prominent, especially during the first pharmacotoxic period and during the first hour of subsequent treatments. Visual hallucinations during toxicity occurred, but were unusual and were rarely experienced following the first pharmacotoxic period. Temporary disintegration of psychic functions was marked. When the patients were aroused from their somnolence they were confused, ataxic, tremorous, dysarthreic, and appeared alarmed. Somnolent periods were interspersed with feeble, confused, poorly coordinated attempts to get out of bed. Light restraints were occasionally necessary. Pupillary dilatation occurred without exception. Widening of the palpebral fissures was usually observed. Urinary frequency was usual. Paradoxical reactions were not uncommon, salivation and pallor being noted. No correlation could be made between this paradoxical reaction and the therapeutic outcome. No patient showed a paradoxical pupillary response. The Babinski response was not con-

sistently present during each pharmacotoxic period, but it was observed in approximately 50% of each individual patient's series of treatments. Weight loss of a few pounds was noted in the vast majority of patients and was felt to be due to anorexia and possibly to increase in basal metabolic rate. Temperature elevations were invariably observed during toxicity. There was no memory loss following cessation of therapy, nor any signs of organic brain damage.

Laboratory Findings.—There was found no significant alteration in the fasting blood sugar curves obtained from 6 patients during a pharmacotoxic period. Cephalin-cholesterol flocculation tests varied from week to week and no correlation could be made between these and the patient's mental condition. There was no evidence of liver damage resulting from the administration of toxic amounts of atropine sulfate. Acetonuria, which was observed in a number of instances, could not be adequately explained but cleared completely when fluids were forced. Occasional transient glycosuria was observed. Weekly nonprotein nitrogen determinations were consistently within the normal range. White blood counts obtained weekly on all patients showed no deviation from normal.

Complications.—Weight loss of a few pounds has already been mentioned and we did not consider this a complication. Nausea and vomiting occurred, but this was sporadic and only one patient was discontinued from treatment because of persistent nausea and vomiting. One patient developed bronchopneumonia and therapy was discontinued after the sixth pharmacotoxic period. Two patients with chronic middle ear disease experienced a "flare up" during their course of therapy. No ocular complications, save for mild transient conjunctivitis, were observed. Within 3 days following the cessation of therapy accommodation was fully restored. One death, in a 53-year-old obese white male, occurred during his first period of toxicity; possibly due to individual sensitivity to the drug. Clinically, death was due to hyperthermia and respiratory failure. An unavoidable break in treatment routine was thought to be largely responsible. A report of this case will be published in the future. An increase in temperature during toxic periods was found so consistently that it was more an anticipated result of therapy than a complication.

Evaluation of Patients.—The following criteria were adhered to:

Worse.—More difficult to care for, regression of mental status.

Unimproved.—No significant change in behavior pattern or mental status.

Slightly Improved.—At least 3 out of 4 of any of the following:

1. Living on a more comfortable ward.
2. More amenable to routine care.
3. Carrying out an assignment or previous assignment at a higher integrative level.
4. Decrease in manic behavior or hallucinations.

Moderately Improved.—All of the above, plus definite, if only partial, decrease of manic behavior, delusions, and hallucinations. Still requiring hospitalization.

Markedly Improved.—All of the above, plus ability to live outside of the hospital or complete remission with return to prepsychotic level of adjustment.

Table 1 shows the results achieved in this group in relation to duration of overt psychosis one week after cessation of therapy. Table 2 indicates the status of patients classified by diagnostic categories 5 to 6 months after cessation of therapy. A number of patients who showed little or no improvement one week after cessation of therapy were observed to have moderately or markedly improved within 12 weeks. It is felt that this explains the higher percentage of improvement in the 5- to 6-month follow-up study (Table 2). Only those convalescent patients who were moderately or markedly improved were counted as being on convalescent status. Table 3 shows the effect of atropine toxicity therapy in this group classified according to the duration of overt psychosis. The duration of illness seemed to have little effect on the therapeutic outcome. Table 4 tabulates the results of atropine toxicity therapy in 40 patients who had received prior electroshock therapy without benefit; 15% of this group left the hospital on convalescent status markedly improved.

Adjunctive Procedures.—Psychotherapy was available to 16 patients in group therapy classes. Increased accessibility was noted by

the therapist. This increased accessibility persisted 5 to 6 weeks after cessation of treatment. Concurrent occupational therapy was available for another group of 10 patients. In general, there was noted improvement in performance and concentration, but the improvement in patients receiving adjunctive therapy was no greater than in those patients not receiving this additional attention.

Psychological Significance of Toxicity.—The psychological significance of repeated periods of toxicity is not clear and is at the present time being investigated. A fear of death during pharmacotoxic periods could be elicited from many patients who were in sufficiently good contact with their environment to give adequate responses. Several patients felt that during toxic periods they "relived old experiences." One recovered patient stated that the drug "cleaned me out." These feelings on the part of patients are suggestive of Meduna's concept of the satisfaction of sado-masochistic desires as being important in metrazol convulsive therapy.

In this series therapy seemed more effective in those patients who exhibited tensional states and whose ego structure was relatively intact. The means through which toxicity permits reintegration requires further study. Perhaps the longer duration of temporary psychic disintegration during atropine toxicity, as compared with that following electroshock therapy, explains the improvement noted in some patients, who had previously received electroshock therapy without benefit.

It is of interest to note the importance Heldt(9) places in the production of a "constructively expressive delirium" in amytal narcosis therapy. He recognizes therapeutic benefit deriving from the production of temporary psychic dysfunction.

We are impressed with the difference in reaction to toxicity with atropine sulfate in psychotic individuals and in those normal people who become toxic with the drug. A review of the literature emphasizes excitement and delirium as being typical. As noted above, this reaction was unusual in our psychotic group.

TABLE 1

RELATIONSHIP OF DIAGNOSTIC CATEGORY AND STATUS OF 183 PATIENTS ONE WEEK AFTER COMPLETION OF ATROPINE TOXICITY THERAPY

	Total		Worse		Unimproved		Slightly improved		Moderately improved		Markedly improved	
Diagnostic category	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Psychoneuroses	10	....	..	..	4	40.0	1	10.0	2	20.0	3	30.0
Manic-depressive (manic phase only)	13	100.0	1	7.7	2	15.4	2	15.4	4	30.8	4	30.8
Schizophrenias												
Unclassified	23	100.0	..	..	15	65.2	3	13.0	2	8.7	3	13.0
Catatonic	17	100.0	..	..	10	58.9	5	29.4	..	..	2	11.8
Paranoid	53	100.0	1	1.9	31	58.5	12	22.3	4	7.5	5	9.4
Mixed	20	100.0	1	5.0	15	75.0	4	20.0	..	..	..	..
Hebephrenic	7	100.0	..	..	6	85.7	1	14.3	..	..	..	..
Psychosis (all others)	11	100.0	..	..	7	63.6	3	27.3	..	..	1	9.1
Subsequent ECT (12% recovered)	25	....	..	..	..	....	..	....	..	..	..	..
Not followed	3	....	..	..	..	....	..	....	..	..	..	..
Died	1	....	..	..	..	....	..	....	..	..	..	..

CONCLUSIONS

1. Pharmacotoxic therapy appears to be a promising field of investigation in the treatment of mental disease. Beneficial results were obtained when atropine sulfate was the toxic agent. Drugs having predominately psychic effects would seem to merit further investigation.

2. Customary dosages with atropine sulfate administered over a long period were ineffective in the treatment of 60 unselected mentally ill patients.

3. The temporary psychic disintegration produced by multiple periods of atropine toxicity permitted reintegration of the shat-

TABLE 2

RELATIONSHIP OF DIAGNOSTIC CATEGORY AND STATUS OF 183 PATIENTS 5-6 MONTHS AFTER ATROPINE TOXICITY THERAPY

Diagnostic category	Total		Worse		Unimproved		Slightly improved		Moderately improved		Markedly improved		Convalescent	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Psychoneuroses	10	100.0	..	..	3	30.0	1	10.0	..	..	6	60.0	6	60.0
Manic-depressive (manic phase only)	13	100.0	..	..	6	46.1	2	15.4	1	7.7	4	30.8	3	23.0
Schizophrenias														
Unclassified	23	100.0	1	4.3	11	47.8	3	13.0	2	8.7	6	26.0	4	17.4
Catatonic	17	100.0	1	5.9	9	52.9	3	17.6	1	5.9	4	23.5	4	23.5
Paranoid	53	100.0	2	3.8	30	56.7	10	18.9	4	7.5	7	13.2	6	11.3
Mixed	20	100.0	4	20.0	12	60.0	4	20.0	..	..	..	...	..	...
Hebephrenic	7	100.0	..	..	7	100.0	..	...	..	..	..	...	..	...
Psychosis (all others)	11	100.0	..	..	8	72.7	..	...	..	..	3	27.3	3	27.3
Subsequent ECT	25	....	..	..	..	...	..	...	..	..	..	...	..	...
(12% recovered)														
Not followed	3	....	..	..	..	...	..	...	..	..	..	...	..	...
Died	1	....	..	..	..	...	..	...	..	..	..	...	..	...

TABLE 3

RELATIONSHIP OF DURATION OF OVERT PSYCHOSIS TO EFFECTIVENESS OF ATROPINE TOXICITY THERAPY

	Worse		Unimproved		Slightly improved		Moderately improved		Markedly improved		
	No.	%	No.	%	No.	%	No.	%	No.	%	
One week after treatment	2	4.7	24	56.0	9	20.9	3	7.0	5	11.6	Duration of overt psychosis less than 1 year —43 patients
5-6 months after treatment	2	4.7	23	53.5	5	11.6	4	9.3	10	23.1	
Convalescent in 5-6 months	..	..	(1)	...	..	...	1	2.3	7	16.3	
One week after treatment	0	0.0	19	59.4	9	28.1	2	6.2	2	6.2	Duration of overt psychosis one to 2 years— 32 patients
5-6 months after treatment	0	0.0	22	68.7	4	12.5	2	6.2	4	12.5	
Convalescent in 5-6 months	..	..	(1)	...	(1)	...	1	3.1	4	12.5	
One week after treatment	1	1.3	47	59.5	13	16.5	7	8.9	11	13.9	Duration of overt psychosis greater than 2 years—79 patients
5-6 months after treatment	0	0.0	48	60.9	14	17.7	2	2.5	15	19.0	
Convalescent in 5-6 months	..	..	..	...	(1)	...	..	..	13	16.5	

tered ego of a number of patients. The psychologic mechanism is unknown.

4. The best response to atropine toxicity therapy was found in those patients with relatively intact ego structure who exhibited tension states.

5. In this series of patients, diagnosis was of greater prognostic significance than duration of illness.

6. Toxicity treatment improved some patients who had received previous electroshock treatment without benefit.

It is apparent that toxic doses of atropine sulfate are necessary to be therapeutically effective. Further investigation into pharmacotoxic therapy with other drug agents appears to be a promising field for research.

TABLE 4

OUTCOME OF ATROPINE TOXICITY THERAPY IN 40 PATIENTS PREVIOUSLY TREATED WITH ELECTROCONVULSIVE THERAPY

	Worse		Unimproved		Slightly improved		Moderately improved		Markedly improved	
	No.	%	No.	%	No.	%	No.	%	No.	%
One week posttreatment.	1	2.5	26	65.0	9	22.5	1	2.5	3	7.5
Five to six months post-treatment	1	2.5	26	65.0	4	10.0	3	7.5	6	15.0
Convalescent	0	0.0	1	(2.5)	0	0.0	0	0.0	6	15.0

SUMMARY

The effect of repeated administrations of 32 mgms. of atropine sulfate to 183 unselected mentally ill patients has been studied. There was one death in this series. One hundred and fifty-four of these cases have been statistically analysed. Five to six months following the termination of therapy the following was found:

Sixteen percent of all patients were on convalescent status, markedly improved. Sixty percent of all neurotic patients were on convalescent status, markedly improved. Twenty percent of all catatonic schizophrenic patients were on convalescent status, markedly improved. Twenty-three percent of all manic-depressive patients, manic phase, were on convalescent status markedly improved. Eleven percent of all paranoid schizophrenic patients were on convalescent status, improved.

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Drug supplied by courtesy of Department of Clinical Investigation, Parke-Davis Company.

PSYCHIATRIC INTERVIEW EXPERIENCES WITH NEGROES [1]

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The Negro occupies a prominent place in psychiatry from a statistical point of view and yet little has been written concerning experiences in psychiatric interviews. Negroes comprise about 10% of the population of the United States(1), and their psychiatric illness rate is relatively high. Much higher psychiatric casualty rates were found in the armed forces(2, 3); Malzberg (4-6) found the overall rate in New York state hospitals to be twice as great; and Wagner(7) found the same to be true in a study at the Cincinnati General Hospital. At the Perry Point, Maryland, VA Hospital there has been a rather constant census of approximately 300 Negro patients and 1,400 white patients, a ratio of 1:4.7. Previous psychiatric studies on the Negro have chiefly focused on morbidity(4-11), sociological problems(12, 13), psychological similarities and differences(10, 14-17) as compared to whites, and special problems among Negro service men (2, 3, 18, 19).

The purpose of this paper is to bring more attention to details observed during individualized clinical contacts with psychiatric patients and to give as much emphasis as possible to psychotherapy. The observations have been based upon experiences over a 3-year period in settings of the military service, the Perry Point, Maryland, VA Hospital, and the children's psychiatric service of the Johns Hopkins Hospital. With the goals of this study in mind, 5 months were spent in dealing exclusively with Negro patients hospitalized at Perry Point. No attempt at a statistical breakdown will be made, but the impression has been in agreement with Wagner's study(7) that functional illnesses are exceptionally frequent. The clinical diagnoses of the patients observed have included a number of organic syndromes, some psychosomatic illnesses, and practically all the functional disorders. The total number of patients seen has been approximately 200. All levels of socio-economic status have been represented in these patients, but the majority were of the lower levels. Some of these were seen for just one interview; the majority were seen for 3 to 10 interviews; about 25 patients were given at least 30 hours of individualized interview; and several much more that 30 hours. Most of the patients observed have been adult males.

It is realized that generalizations are dangerous and that individual patients must be treated as individuals who have considerable differences in their make-up, yet there seemed to be a number of clinical features observed with sufficient frequency to deserve special notation. These particular features will be listed and an emphasis will also be given to attitudes of the therapist.

The Difficulty in Establishing Rapport and Securing a Therapeutic Relationship

Frank(18) has made special mention of the difficulty in establishing rapport with Negro patients, and the writer has found similar difficulties. Irrespective of all the usual difficulties in establishing rapport with any patient, there seemed to be 2 special reactions and sets of attitudes given more emphasis by Negro patients during interviews that made for difficulty in establishing a therapeutic relationship. The patients were either suspicious or submissive, or both.

The suspiciousness would take many forms, such as uneasiness, a wary look, sullenness, a hesitancy and reserve, open and frank remarks questioning the doctor about his status, a tendency to avoid any mention of psychological material with a resultant emphasis upon physical complaints, silence, and the like. This "suspiciousness" and in-

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itial fear with its various means of expression would seem to be greater than that seen in white patients, and it would suggest that racial factors may play a part. The Negro would seem to mistrust the white physician. This feature of suspiciousness might appear to give a paranoid coloring in some individual patients, but it was found to be so frequent and to be so separate from real paranoid material that it would certainly suggest that it is attributable to the fact of Negroes mistrusting and resenting white men, the therapist being white. The therapist should guard against thinking, "This patient is paranoid!" Certainly this suspiciousness is seldom observed with Negroes when they meet with one another. A few patients have remarked, "You know, Doc, I thought you were just another white man at first. I couldn't talk to you then."

The "submissive" attitude was more obviously observable, even when it was mixed with suspiciousness. It took many forms: an excessive politeness, a ready agreeableness, a willingness to please, a disproportionate laughter, a quiet acquiescence, a "Yassuh, Boss!" attitude, an eagerness to curry favors and to be "nice." (This attitude was even displaced onto the writer's automobile—it had much washing and polishing that neither it nor its owner ever asked for while parked outside an all-Negro ward, and this never happened on the predominately white wards.) Patients never brought this attitude out into the open during interviews and the therapist never pointed it out to a patient. From a dynamic point of view it is felt this "submissiveness" is probably a result of repression and suppression of intense resentment of the white man, that the Negro fears the threat of retaliation by the white man and wishes to protect himself by disguising his fear and hate behind a placating submissiveness. The white physician is still a white man and a figure of authority to the Negro patient.

These none too subtle ways in which the Negro presents his fear and hate of the white man make stumbling blocks for the development of a therapeutic relationship, and can best be met by a combination of patience, a careful permissiveness, and a constant conveyance to the patient of a sincere interest in what he, as a human being, is trying to present as his problems. It is found best to do very little direct questioning of a leading nature, to do as little talking and be as passively attentive as possible, to "agree" with the patient so long as one can be honest in doing so, and to answer questions most frankly, and not try to be "subtle." The patient is thus given every opportunity to feel that the therapist is permissive and not aggressive, is honest and "above board," and will not try to trick the patient. It was surprising how this prompted a feeling of security for the patient and how rapidly he would respond, even though cautiously, and would then begin to unfold his personal problems. Occasionally it would happen that these attitudes of the therapist would be known to the patient even before the first interview, in which case rapport was even more readily established. Two patients can be recalled who introduced themselves by saying, "I'm glad to get on your ward, doctor. I heard you're a doctor we can talk to."

These difficulties in establishing rapport are different from the white patient's only in degree. It would seem that racial factors have much to do with the greater degree.

The Theme of Race-Consciousness

It was noted that although many different personal problems would be given emphasis by the patient there was a constant theme of race-consciousness, either far in the background or quite prominent. This has a tendency to be lost in the shuffle of the patient's more personal problems unless one is looking for it.

For example, one married patient, who was separated from his wife and living with his mother, gave abundant evidence to indicate that he was a very dependent person who preferred the indulgence of his mother to the responsibilities of a relationship with a wife who was not particularly indulgent. He later mentioned that it was difficult to get housing, that rent was high, that his wife had not been faithful (she had to live in another city with her folks because she and the patient's mother did not get along and the patient could not afford separate housing), and that he didn't make very much money. All these items, even though they were mentioned by the patient chiefly as rationalizations for his primary problem of dependency, still had some reality factors of housing difficulties and salary limitations related to being a Negro. One might well question if being a Negro had anything

to do with this, and although this patient never voluntarily mentioned racial factors *per se*, it was still the opinion of the therapist that they were there. This was mentioned to the patient and he unloosed a tirade of bitterness about Negro discrimination. He then quickly blamed his symptoms on racial discrimination rather than his own inadequacies and his desires for a dependent relationship with his mother. With some prompting by the therapist he resolved to "fight" this racial issue constructively by redoubling his efforts to establish an independent security away from his mother. He was "fighting mad" enough to want to get a job, separate housing, and a reconciliation with his wife. His symptoms promptly receded.

When racial matters were brought up voluntarily, which was seldom, it was found that they were usually on a reality level. Sometimes, however, racial discrimination was used as a rationalization by the patient for concealing more important dynamics, usually those involving rebellion against figures of authority. The therapist found that in brief psychotherapy it did not seem helpful to point this relationship out to patients as they felt that the therapist was belittling the racial discrimination, and this alienated the therapist. In more intensive psychotherapy the relationship between racial resentments and rebellion against authority should of course be brought out at the proper time.

The theme of race-consciousness also had importance in dealing with feelings of inadequacy and defeatism, and it was useful therapeutically to point out tactfully the possible connection between being a member of a persecuted minority and the person's feelings of being an underdog and feeling inferior. This again served to stimulate and mobilize the patient's anger, and afforded the opportunity to direct the patient's pent-up hostilities onto external factors rather than upon himself.

The Prestige Factor

Being in a striving minority group makes for an emphasis on prestige factors. Because of economic and social discrimination, the Negro has much actual insecurity and resentment. What little prestige the Negro can secure gives him, by so much, a feeling of security and an unconscious satisfaction of revenge. Money, church activities, sexual prowess, social clubs, and social position within the race itself are dominant as such prestige factors. Often, prestige is above ethics; and any shady method of gaining money, sexual conquests, etc., is not considered quite as unacceptable by the Negro culture, particularly the lower socio-economic cultural group. One should consider this cultural phenomenon when looking for motivations of thought and behavior, and as an area of conflict. These characteristics vary of course from individual to individual and are of special significance in therapy in that they tend to make the therapist think, "How can I ever hope to modify this person's attitudes when he seems so content with these things I would consider psychopathic?" When the therapist considered that these attitudes were needed for prestige reasons, his own attitude changed, goals in therapy were accordingly changed, and therapy was more successful.

When patients would speak of wanting to move out of a neighborhood that was "not a good one," they were often referring to their social status, and it behooved the therapist to pay special attention to this. When a patient disclosed that he occasionally was a thief, or prided himself on owning an automobile with all the flashy gadgets, or gave much attention to being a "sharp dresser," it was not good for the therapist to have a critical attitude. Similarly, if the patient gave a complaint that his "nature" (potency) was leaving him, it paid dividends for the therapist to take this as a very grave prestige issue.

In addition to the therapist modifying his own attitudes as just described, it was found that techniques of boosting self-esteem were highly effective, inasmuch as these promoted more feelings of prestige and thus security. These should embody sincerity and reality and not be just pats on the back.

One patient became quite vehement and insisted that his whole illness was due to the fact that he had been one of 3 Negroes among a detachment of 250 white men on an island in the Pacific for many months during the war. He bitterly and sarcastically gave vivid examples of racial discrimination and white brutality. He cursed the Navy and all it stood for and was ready to attack the therapist if the latter didn't agree with everything he said. The therapist considered that most of what the patient said was true, and that it was also true that the patient was using this as a rationalization for other hatreds, particularly the hatred

for his parents as authority figures, as his next associations indicated. Rather than point out the connection between the Navy and his parents, as was the therapist's first impulse, he agreed that the patient had had a very humiliating and maddening situation, but suggested that perhaps a different point of view might be taken, in that he as a Negro had been in the Navy, had taken a lot of mistreatment, and yet done his part to improve racial relations in the Navy; and that as a result of his and other Negroes' service the attitude of the Navy and the country in general toward Negroes had improved from what it had been before the war, and that this was something of which to be proud. His attitude changed instantly from bitterness to pride, and because of his needs for self-esteem, security, and revenge he then even bragged a bit. It was then possible to point out to the patient that perhaps he was sensitive about being bossed around unfairly because he had had that same issue with his mother.

A Tendency to Act Out

Another special feature noted was what might be termed the "tendency to act out." It is known that juvenile delinquency and criminality(11, 20, 21) are proportionately higher among Negroes, that the ratio for the criminally insane is 4 to 5 times greater(5), that the "psychopathic states" were observed proportionately more commonly in the armed forces(2), that there are proportionately more childhood behavior disorders(21), that emotionalism, a capacity for so-called laziness(21), special musical abilities, impulsiveness, dramatization, and other singular qualities have been both popular conceptions and mentioned in various publications. The writer's own clinical impressions seem to confirm some of these conceptions. Regardless of the clinical diagnosis there did seem to be much emotionalism, a greater affective demonstration, more alcoholic intake, more exhibitionism, more motor activity in general, more psychopathic-like reactions. This tendency seemed to be directly correlated with the socio-economic and educational levels; and in that respect perhaps does not distinguish the Negro from white people from comparable levels. Just why this characteristic exists is not clearly understood. Some have felt that it was anthropologically determined. Bender(21) mentions that the capacity for so-called laziness and the special ability to dance may be because of specific brain impulse tendencies. Pasamanick(22) gives convincing evidence that it is an acquired characteristic. His studies on Negro infants up to the age of 18 months concluded that in "gross motor, fine motor, adaptive, language, and personal-social fields" there are no deficiencies or differences, and that there were "no basically racial characteristics." It is probably true that because the parents themselves indulge in more "acting out" the children learn to do so by identification and imitation. Then it might also be supposed that because of the high number of broken homes found in Negro culture the child has less instruction and guidance in learning patterns and methods of control of his impulses.

The therapist found no really effective means of dealing with this tendency. It was examined therapeutically, to reveal motivations to both the therapist and the patient, and to afford an opportunity for discussion of attitudes and behavior.

One patient, while intoxicated, climbed the hospital water tower and put on quite a histrionic display by swinging around the tower and threatening suicide with dramatic gestures and a rich vocabulary. He was later able to discuss his wishes to be a "big shot," his resentment toward both his girl friend and his mother, his disappointments in his vocational activities, and his feelings of inadequacy by discussing what his thoughts, feelings, and actions had been while up on the water tower.

There is a therapeutic disadvantage to this so-called acting-out tendency; such behavior can give the therapist the impression that the patient is "psychopathic." The therapist may then tend to become exasperated to the detriment of the therapeutic situation. To avoid this pitfall it is necessary to view this acting-out tendency as an opportunity to discuss motivations and feelings.

The Problem of Hostility

Hostility seems to be a dominant and difficult problem for Negroes. It takes many forms of expression and is particularly difficult to handle therapeutically. Besides the usually encountered sources of hostility in these male patients, there seemed to be two additional sources, both culturally determined: first, the frequency of matriarchal homes with harsh and unstable fathers, thus exposing the patient to a childhood with a

frustrated and insecure mother and a rejecting father, resulting in a great deal of hostility toward father and other male figures of authority, and a concomitant strong dependency upon and unconscious hostility toward mother; and second, the hostility from racial prejudices and inequalities, which is lifelong, inescapable, and quite conscious. Holloman(23) concluded that the Negro's supremacy in white athletic competition was because "of racial hatred and a desire for revenge, his efforts to compensate for feelings of inferiority, and a desire to overcome his oppression by identification with the majority group." Bender(21) states that racial conflicts are seen in children. The writer's own experience confirms this, as his first bloodied nose came at the age of 5 years when he called a Negro playmate of the same age a "nigger."

Because of the prominence of hostility it is felt that it should be given particular attention during therapy. It is difficult to get a patient started in telling of his hostilities because of his reserve with the white therapist, but once he does, it is most valuable. It was noted that the most successful clinical results were gained with those patients who could, with encouragement, bring their hostilities out in the open and find constructive outlets for aggressive impulses.

A Difficulty in Expressing Hostile Feelings toward the Therapist and an Apparent Agreeableness

It was noted that the Negro patient had difficulty in expressing any hostile feelings toward the therapist. He would freely discuss his hostility toward various situations and people, including white people in his life, but he suppressed and attempted to disguise his hostility toward the physician. His submissiveness came into action here and this would at times even give an impression that he had developed a strong dependency upon the physician. This concealing of hostility by submissiveness and a pseudodependency did have some therapeutic advantages as well as disadvantages. The therapist felt that, probably as a result of this defense pattern, the patients, generally speaking, felt guilty and to atone for this were more agreeable to what the therapist had to say. Just how much each patient appeared so because of his wish to appease guilt feelings and how much because of his wish to placate is difficult to say. Then, too, other factors, such as the wish to be accepted by the white majority group by being like the white, and the "habit" of being "bossed" by whites, may be important in this respect. Regardless of the etiology of this agreeableness, it did seem to give the therapist more liberties and opportunities to suggest different points of view for the changing of perspectives and attitudes.

It was noted as a general characteristic that the patients were quite "obedient" and would follow treatment suggestions carefully. Suggestions about occupational therapy, things to do on the ward, and different attitudes to think about in relation to problems were seemingly accepted readily.

A patient, who was bitter toward his wife whom he had deserted and with whom he had previously refused to correspond for a period of 5 years, emphatically stated that he wouldn't have anything to do with her. He was asked, "Well, maybe she's changed—why don't you write to her? She might not be as bad as you think." The patient reflected on this, replied to the effect that maybe that was so, and the following day announced that he had written her a long letter, was feeling much better, and was thinking that a good bit of the fault was his and not hers. Although this incident is separated from context it does seem to illustrate a more than expected agreeableness.

Sexuality

It has been a popular misconception that the Negro is sexually different, being endowed with more libido and expressing it more freely. Overt sexual behavior and sexual conflicts in Negro psychiatric patients seemed to show no qualitative or quantitative differences to whites, when levels of education, social status, economic status, etc., were similar. Although Kinsey(24) feels that not enough Negroes have been studied as yet to draw any statistical conclusions, he does state: "It is already clear that Negro and white patterns for comparable social levels are close if not identical." Discussions concerning sexual feelings and behavior were handled no differently than with white patients.

An Emphasis upon Bodily Complaints

It was observed that most of the patients had a more than expected emphasis upon bodily complaints. Somatic complaints appeared to have multiple meanings for a patient. Physical health and virility have special values for the Negro in terms of security and prestige, hence there is more anxiety about health. Such complaints make it easy to avoid the discussion of personal issues that the patient felt could not be understood. They also served to test the doctor's interest in the patient and his illness. The importance of the latter consideration made it seem proper, and experience showed that it was useful in the early phases of treatment, to provide symptomatic relief by medication, unless a very easily acceptable connection could be found for the patient between the somatic symptom and his attitudes and feelings.

The Importance of Recognizing Social Status of Individual Patients

The obvious is often forgotten or ignored, and the writer found this true for himself and for other white personnel having contact with Negro patients in that there was a tendency to forget that the Negro has as much variation in cultural levels as any other racial group. As an aspect in therapy it seemed important to size up the patient's cultural level as soon as possible for two reasons: one, it gave the therapist a better orientation of the patient and the probable goals in therapy; also, the cultural level or social status often played a part in the individual motivations and therefore had some connection with the patient's illness. A higher class Negro tends to be excluded from his own race as well as the white race and is apt to be touchy on many subjects because of his precarious status, and the lower class Negro is apt to be more suspicious and submissive with the white physician. The second aspect, that of the significance of social status in the dynamics of the patient's illness, was manifested in two ways: first, in the personal problems of striving for intraracial advancement, and second, in the resentment of white restrictions on Negroes, particularly those of the middle and higher classes. For example, an ambitious patient, who was of lower class background and who, before he had advanced to middle class status, had married a girl of lower class status, developed considerable hostility toward his wife because she seemed content to remain in lower class in her attitude and conduct and he was intolerant of this. Then those patients with college degrees or with some collegiate training who could find employment only in unskilled or semi-skilled labor because of the job ceiling restrictions placed upon the Negro would obviously have problems in this area. This was discussed with several such patients and it was impressive how much relevance this had with the precipitating stresses of the illness. This factor of socio-economic status of the Negro is not an isolated or compartmentalized stress but is interwoven into his personality in many ways.

SUMMARY

Some observations upon Negro psychiatric patients have been recorded. These observations were made clinically during personal interviews for psychotherapeutic purposes, and were done in the setting of the military service, a VA hospital, and a children's psychiatric service over a 3-year period. Most of the observations were with adult males, the majority of whom were from lower socio-economic levels.

It would seem that psychotherapy is not different with Negro patients than with white in respect to general principles and techniques, but that the establishment of rapport, the use of the patient's agreeableness, the importance of dealing with hostility, and the use of promoting self-esteem are of special significance. Some features which have been recorded as clinical impressions are the frequency of functional illnesses, attitudes of suspiciousness and submissiveness, a constancy of race-consciousness, a difficulty in achieving expression of hostility toward the therapist, an agreeableness, an emphasis upon prestige for its security value, a tendency to "act out," a special emphasis upon hostility in individual psychodynamics, no racial differences in sexuality, an emphasis upon somatic complaints, and the importance of the

therapist's recognizing socio-economic and cultural levels in individual patients. Some of the therapeutic implications of these features have been discussed. In general the impression has been gained that the various sociological and psychological factors of a minority group and a group whose socio-economic level is lower must be given more consideration in the understanding of the Negro's symptomatology and therefore in treatment.

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INFERIORITY FEELINGS AND HOSTILITY

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"———————— So with outragious cry,
A thousand villeins round about him swarmed
Out of the rocks and caves adjoining nye;
Vile caitive wretches, ragged, rude, deformed;
All threatening death, all in straunge manner armed;
Some with unweldy clubs, some with long speares,
Some rusty knives, some staves in fier warmd."

—Herman Melville

This short theoretical note is a distillation of some years of clinical observation. For this reason and because other observers can readily check the formulation herein given by reviewing their own material, it is unnecessary to present the body of data upon which it rests.

Our purpose is to provide a formulation that is comprehensive and yet is reduced to the simplest possible terms. What contribution there may be lies in this, rather than in any new discovery about inferiority feelings.

The sense that one is in some way inferior either to other specific persons, to other people in general, or to what one should be appears to be ubiquitous if not universal in our civilization. Disguises for these feelings are generally unsuccessful. It takes no unusual observer to recognize that beneath inflated egos are regularly insecurity and feelings of inferiority. These feelings of inferiority play a vital role in generating rage and hostility and hence they are of central significance in all human relationships.

The source of feelings of inferiority is, stated generally, actual inferiorities in the emotional life. These consist in all manner of impairments and deformities in the emotional development. The twig has been bent and the inclined tree senses its deformity. Put most generally, feelings of inferiority result from actual emotional inferiorities that represent failures to develop fully to emotional maturity. This failure results, exclusive of hereditary defects, from the myriad terrible abuses to which our children are subjected in their upbringing during their very earliest years—from birth, or shall we say from conception, up through the years of childhood, especially the very earliest years, during which, as we know, the basic pattern of the personality is laid down. Probably the earlier the improper and malign influences exert themselves upon the child the greater the deformity of the personality later—just as a pin prick in the embryo in its early stages can produce a monster while a pin prick in the well-developed fetus or the newborn child is only a scratch and does not produce a misshapen organism.

The various distorting forces that warp the mind for life are well known to psychiatrists and social workers and others who have made a study of them. They spring from the blunders of well-meaning, loving parents as well as from the sadism of malicious ones. The abuses may be subtle, hidden behind a guise of enveloping love, or they may come into the open as direct cruelty and even violence. Whatever their nature, overprotection, neglect, inconsistent training, excessive ideals, debased standards, seductiveness, exploitation, and open hostility, whether stemming from misguided love or conscious sadism, the result is some form of crippling of the emotional life.

What constitutes this sense of emotional crippling is not usually conscious. Rather the individual is apt to feel that something is wrong without quite understanding what it is. The impairment may be in any or all parts of the personality. It may be primarily a reaction of the id, for example, excessive dependence upon one or the other parent; or it may lie in a disorder of the superego, for example, in guilt, in superego harshness, in false standards, even in training the child to ideals so high that they are impossible of fulfillment. The lack of good loving persons with whom to identify during earliest years of childhood can be one cause, among many, of weakness of the ego. Such

a person may have a poor sense of reality, poor will power, and poor control over his or her various impulses.

Whatever the specific nature of the personality deformity one result seems to be invariable, namely, the sense of inferiority, which sense may indeed not even be fully conscious. As seen in our culture the sense of inferiority is usually reacted against violently. It is an intolerable internal irritant and a threat to one's security. It is not our purpose to list all the ways in which different individuals react against their feelings of inferiority. Three of these, however, merit mention.

The first is "narcissistic overcompensation," in other words exaggerated pride and egotism. Stated schematically, the unconscious is the child that lives in every adult. The child is normally loved by its parents. It is quite normal and proper then for the adult to go on wanting to be loved and valued, and endeavoring to supply these commendations to himself if they are not adequately forthcoming from others. But what we see in individuals in real life is not usually this moderate and wholesome self-interest, but rather such enormous and ruthless inflation, pride, and overestimation as led the prophet to say "vanity of vanities all is vanity." Clinical observation show that this mushroom growth of prestige needs, with all its dangers to the individual and to others and with the potent part that it plays in groups and even between nations, has one of its roots in the feeling of inferiority.

Closely related to this reaction is the lust for power. Power is the great assurance that one can satisfy his needs in spite of all. Power is what the little child most conspicuously lacks. Hence if he suffers he wishes to be like those who have the power over himself. Every one sees the world in terms of the little intimate relationships of his childhood. He cannot ordinarily imagine anything new. He can only imagine exchanging his own position in these relationships for the position of another. Whether an adult seeks power in order to make a constructive contribution to suffering humanity or whether he wants it because of his inner personal needs is a test of his degree of emotional maturity.

The third, and the most important, for the individual and for society, of all the reactions to feelings of inferiority, is hostility. Any irritant is reacted to by every animal organism with mobilization for fight or flight. This is a reaction to the inner irritation from inferiority feelings just as it is to any external threat. The individual feels a nameless, indefinable inferiority. He may not even admit this to himself. Without any analytic treatment he cannot come to grips with its sources. He may try to change but the core of the personality being fixed as it is he is unable to do so. He is threatened but he cannot change, he cannot flee, and he cannot fight the threat itself. The usual result is what has been aptly termed "impotent rage." Irritated and threatened from within, the individual generates a constant pressure of rage and hostility that can come out in various directions—against the strong who remind him of his inferiority and whom he bitterly envies,[1] or against the weak who, because of their own weakness, also remind him of his own inferiority.

The following diagram summarizes what has been said:

Influences harmful to the child's emotional development →	Impairment of the personality (real inferiority) →	Feelings of inferiority, more or less conscious →	Irritation, insecurity, anxiety →	Various reactions against this; among them 1. Overcompensatory egotism 2. Need for power 3. Rage and hostility

Because of the awful abuses of children a high proportion of individuals are filled with feelings of inferiority and with reactions of pride, power-seeking, and hostility. It is these that make the profound problems of our world. Few indeed of our important problems cannot be solved by knowledge, reason, and technical skill. Few academic

[1] "All the conspirators, save only he,
Did that they did in envy of great Cæser;"
—SHAKESPEARE

problems could not readily be solved by the parties getting together in a spirit of *good will*. What engenders the anxiety, pain, and suffering between nations, within nations, and even in professional societies is the pride and hate—each man thinking that he knows better than the other and ruthlessly willing to impose his will with little capacity for sympathetic understanding of the other person. These are usually characteristics of emotional cripples. They are one of the most important sources of group tensions. They spell failure to achieve object-interest, that is, the ability to love. Freud has commented upon Shakespeare's Richard III, who used his physical deformity to excuse the hate and cruelty that stemmed in reality from his crippled personality. Any person who shows exaggerated egotism, need for power, and above all, hostility, is apt to be an emotional cripple. It is of practical importance that this be recognized.

SUMMARY

Feelings of inferiority generally stem from warping and impairment of the emotional development, which result from various abuses in the rearing of children. The feeling of inferiority, which may or may not be fully conscious, is reacted against in a number of ways, of which three are of particular importance; overcompensatory egotism, power-seeking, and hostility. We live in a world in which feelings of inferiority are widespread. This betokens a widespread amount of emotional crippling. Emotional cripples, reacting against their feelings of inferiority with exaggerated egotism, power-seeking and hostility, should be recognized as such, for they play an important part in creating the problems of the world, between nations, within nations, and even in small groups.

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THE DIAGNOSIS OF SCHIZOPHRENIA

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At the First International Congress in Paris in 1950 the problem of the diagnosis of schizophrenia was subjected to extensive discussion in several discussion groups. "The Subdivision of Schizophrenia" was listed as a separate topic, but also, at those symposiums where the various indications for shock therapy and the somatic findings in schizophrenia were discussed, the question of what should be understood by the term "schizophrenia" was an ever-recurring problem.

During a study trip to the United States a couple of years ago I particularly noticed how the diagnostic concept of schizophrenia varied from one clinic to another. Nevertheless, the problem concerning the extension of the concept of schizophrenia is of major importance for the study of etiologic and prognostic aspects of the disease as well as for the evaluation of the effects of various methods of treatment.

Despite this fact, two of the three opening speakers on the subject of "The Subdivision of Schizophrenia" (A. Lewis, London; L. Bini, Rome) found no reason for suggesting any changes in the classification originally given by Kraepelin. The third speaker, the author of this article (G. Langfeldt), on the contrary strongly emphasized the necessity of separating as a special group those cases in which, as shown by catamnestic studies, the disease runs a course different from that in cases characterized by the Kraepelinian symptomatology (1, 2).

Reporting on the indications for various methods of shock therapy (reports read before the First International Congress in Paris in 1950) Meduna and Lopez Ibor strongly emphasized that the effects of shock therapy on genuine schizophrenias and on schizophrenia-resembling conditions must be evaluated separately. Reference may also be made to Bellak's (3) extensive studies of publications on dementia præcox and his conclusion that the large group of schizophrenias should be divided into at least two subgroups, *viz.*, genuine *dementia præcox* contra all other schizophrenic psychoses. For the latter he suggests the term *schizophrenia.*

It was the critical observations of von Meduna in 1935 concerning the indications for cardiazol treatment as compared with Sakel's enthusiastic report of an 88% cure in "schizophrenia" by means of insulin coma therapy that initiated my catamnestic studies of nontreated cases of psychoses usually diagnosed as schizophrenia. At the University Psychiatric Clinic, Oslo, it has been the practice ever since its opening in 1926 to record either one or two question marks along with the diagnosis in all schizophrenic cases where some doubt existed as to the diagnosis, while typical cases of schizophrenia have been diagnosed as such. A follow-up study (6 to 10 years after discharge from the clinic) was made of 100 cases of "typical" schizophrenia that had been hospitalized during the period 1926 to 1929, as compared with a similar number of cases of "doubtful" schizophrenia ("schizophrenia?") hospitalized during the period 1926 to 1930. The study revealed a considerable difference as to various etiologic, symptomatologic, and prognostic factors in the two groups. The investigation was performed by means of individual follow-up studies, most patients being visited in their homes. Also, in all cases an elaborate history was obtained as to the further course of the disease following the patient's discharge from the clinic. For further details reference is made to the above-mentioned monographs. In this connection, however, the following features may be worth mentioning.

Of the 100 cases of *typical schizophrenia* 66 were found to be unimproved or worse after 6 to 10 years; 13 were improved, 4 cured with defects, and 17 completely cured. A catamnestic study of these 17 cases, however, showed that, on the basis of the development and initial symptoms of the disease, 14 of them should have been diagnosed

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as *doubtful* schizophrenias calling for one or two question marks after the diagnosis.

Among the 100 cases diagnosed as *doubtful schizophrenias* ("schizophrenia?") 43 were found to be unimproved or worse; 25 were improved, and 32 completely cured. A catamnestic study showed that among the *cured* cases there was only one in which the disease might be considered a psychosis of the same nature as those that in the preceding group resulted in defective states, while among the 43 unimproved cases there were not less than 36 cases that according to the development and symptomatology of the disease should have been diagnosed as typical schizophrenias.

These follow-up studies show that a comparatively high proportion of cases commonly diagnosed as schizophrenia yield a favourable prognosis as compared to the nonamenable typical schizophrenias. A diagnostic differentiation as to this point, however, may be very difficult during the initial stage of the disease. The evidence revealed by these and other follow-up studies, however, has greatly facilitated a more accurate diagnosing of typical schizophrenia. Typical schizophrenia I define as psychoses that *as a rule* (but not constantly) show an insidious development resulting in a gradual change of personality and with a typical initial symptomatology. A detailed description of the symptoms characterizing this group is not indicated here, and reference is made to my previous publications. On the whole the group coincides with the Kraepelinian dementia præcox groups. It may be mentioned, however, that the paranoid psychoses in which prolonged symptoms of depersonalization and derealization are the main feature (without otherwise impaired consciousness), like the typical hebephrenic states, are regularly typical schizophrenias yielding a poor prognosis.

It is to be hoped that one of the positive results of the First International Congress will be that all investigators studying schizophrenia in the future will specify whether their observations only refer to cases of strictly typical schizophrenia or whether also doubtful cases are included in the series reported. In 1937 I suggested that all cases of schizophrenia except the typical ones be recorded as "schizophrenia?" or "schizophrenia??" (depending upon the degree of doubtfulness of the diagnosis) and be termed (in statistical surveys, etc.) *schizophreniform psychoses*. If this had been done for the last 10 to 15 years, agreement would no doubt have existed today as to the much discussed problem of whether or not the typical or genuine schizophrenias, which usually yield a poor prognosis, are amenable to various forms of shock therapy.

Thanks to Meduna's early discernment in this field and to a number of recent observations, it seems an established fact that cardiazol treatment is ineffective in genuine endogenous schizophrenia, while the schizophreniform psychoses, including Meduna's oneirophrenia, seem to respond favourably to this treatment.

Personally, I have for more than 10 years in various publications maintained that this applies to the response to electric shock treatment as well. As regards insulin coma treatment it seems that some psychoses belonging to the schizophrenia group respond favourably to this treatment. Conclusive studies, however, in which due consideration has been given to whether typical schizophrenias or schizophreniform psychoses have been involved are very few.

Besides a division of the extensive group of schizophrenia into 2 subgroups it is no doubt of great importance that the individual subgroups be properly defined in all papers published. I have in a previous monograph (4) given conclusive proof that fundamental variations in blood picture, basal metabolism, adrenalin-pilocarpin and atropine reactions, etc., exist between the various Kraepelinian dementia præcox groups. Also, most varied somatic pictures may be encountered within the various groups, depending upon the *phase* of the disease in which the examination is made. These problems have been subjected to extensive research in well-equipped modern laboratories. Interest has particularly been focused upon the function of the hypophysis and adrenal cortex in schizophrenia. Nevertheless, the results as published from many American university clinics only refer to those obtained in "schizophrenia" without

any reference to the form or phase of the disease. Even though the many varieties of typical schizophrenia may prove to have a common cause, the various forms (hebephrenia, catatonia, paranoid types) as well as the different phases of the disease must be considered related to a number of most varied biologic factors.

The aim of this paper is to stimulate American investigators who are carrying out such an intense and auspicious work in this field to differentiate their schizophrenia cases to a further extent than they have hitherto done. A simple procedure such as the recording of either one or two question marks along with the diagnosis in doubtful cases would supply adequate means for a more accurate comparison of various statistics, and would certainly be highly profitable.

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CORRECTIVE EMOTIONAL EXPERIENCES IN GROUP THERAPY [1]

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With improved understanding of the dynamics of human behavior there has developed a greater appreciation of the importance of difficulties in interpersonal relationships as both expressions and sources of distorted attitudes, which may lead to the production of neurotic or psychotic symptoms. These may assume such proportions as seriously to interfere with an individual's functioning and prevent him from fully utilizing his assets. The goal of dynamically oriented psychotherapy is modification of the individual's noxious attitudes, thereby liberating those forces that enable him to carry on in his daily tasks with an optimally low degree of disturbance to others and of anxiety within himself.

A promising means of bringing about such changes is the treatment of patients in small groups in which the doctor's efforts are directed primarily to producing a situation in which patients feel free to express and examine their feelings toward people in their own lives as well as toward the doctor and each other.

In conducting and observing therapeutic groups the authors have been impressed by the occurrence of crucial events that were followed by what seemed to be remarkable changes in patients' attitudes. The significance of emotionally traumatic episodes in producing mental illness has long been recognized and was again confirmed by experiences in the last war. The role of emotional experiences in the resolution of neurotic patterns has received less attention. In the course of psychotherapy some patients, in spite of gaining remarkable "insight," show no change in their patterns of living. This indicates that mere intellectual understanding of the nature of one's difficulties need not lead to any modification of behavior. Other patients, however, go through repeated emotional displays without showing hoped-for changes in attitude, indicating that expression of emotion *per se* is not necessarily therapeutic. In contrast, some persons with stubborn neurotic difficulties may show marked improvement after a critical emotional experience without ever having received formal psychotherapy. It would appear that both in and out of therapy emotional experiences may create "an internal crisis in which habit is interrupted and the more . . . . primitive faculties for biological adjustment are summoned up"(1) leading to a change of attitudes. The crucial problem is to determine why some emotional experiences lead to such change when others do not. The former, which have been termed "corrective emotional experiences,"(2) seemed to be facilitated by certain therapeutic processes that can be considered under the following headings: (1) support, (2) stimulation, (3) reality testing. Despite divergent views as to what is actually therapeutic in psychotherapy these factors are generally recognized as being involved in bringing about modification of attitudes.

(1). *Support.*—Persons with mental illness characteristically suffer from more or less severe lack of self-confidence, which hinders them from utilizing their assets fully. In order to find the courage to change their attitudes they often need the support of another person. This may be given through sympathetic appreciation of their lot or even through the other person's mere presence. Psychotherapy must supply such support in accord with the patient's needs. This may be difficult in individual treatment because on the one hand patients oriented to prestige and self-respect may find any degree of dependence on the doctor intolerable, while on the other some all too readily welcome his sup-

[1] From the Group Psychotherapy Research Project sponsored by the Veterans Administration and published with their approval. In addition to the authors, the research staff consists of Joseph B. Margolin, M.A., Helen T. Nash, M.A., Anthony R. Stone, M.S.S.W., and Edith Varon, M.A., M.S.

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port and are so dependent upon it that they react with exacerbation of symptoms whenever this support appears to be in any degree withdrawn or threatened.

The problem of dependence tends to be less troublesome in group therapy because patients, in groups, derive support from each other as well as from the doctor. Because of this interdependence, support is apt to be felt as coming from the group rather than from any one individual. This may make it more acceptable in that no obligation to any single person is incurred. It also reduces the patients' dependence on the physician.

(2) *Stimulation.*—It may be therapeutically useful to stimulate attitudes causing trouble so that the patient can become fully aware of his inappropriateness to his present circumstances, if opportunity and incentive to change the noxious attitudes can also be arranged. In individual therapy the doctor tries at appropriate times to activate these attitudes by eliciting the patient's accounts of his relations with other people and especially by examining the attitudes he shows toward the doctor. These are sooner or later interpreted as constituting repetitions of attitudes shown to important people in the patient's daily environment, present or past. The doctor points out the differences between himself and the persons from whom the feelings had been "transferred" to him. It seems that the main stimulus for attitudinal change lies in the doctor's activities, or rather what the patient perceives them to be. Opportunities for this stimulation are limited in individual psychotherapy by the fact that the doctor-patient relationship is one of special favor, insulated somewhat from the reality-laden struggles of everyday personal inter-action. In the group setting, competition for the doctor, struggles for status, differences in background and outlook among patients, transference reactions to other group members, and so on, afford ample opportunity for the activation of such noxious attitudes.

(3) *Reality Testing.*—Mental patients' perceptions of their relations with other people and their expectations from them tend to be distorted by the persisting effects of disturbing experiences with people in their past. Many of the difficulties of neurotic and psychotic patients spring from reactions that, though once appropriate, are inappropriate to the present situation. Psychotherapy tries to help patients to correct such distortions by bringing them to awareness under conditions that may favor a helpful revision. The patient may then be able to test the results of the revised attitude in his daily life. This reality testing, which is an essential aspect of therapy, presents a particular problem for individual treatment because the psychotherapeutic interview is an unreal situation. The relationship is artificial in that it is a one-way street, the patient being expected to explore himself without reservations and the psychiatrist revealing as little of himself as possible and maintaining an almost completely permissive attitude. While this sort of relationship may be necessary to help a patient face the feelings that he regards, often correctly, as unacceptable to the world at large, it may leave him uncertain as to how others will react. The patient must still test his attitudes outside of the therapeutic situation.

The therapeutic group, in contrast to the private interview, is more like society in miniature. Members of the group may be representatives of types of people with special meanings for the patient. A worker having difficulty with bosses, for example, may in a group be exposed to other workers with attitudes similar to or divergent from his own, and to employers as well, and thus be enabled to test his attitudes with both groups on the spot. Members of such a group, furthermore, are not schooled to conceal their feelings. In fact, feelings tend to be expressed more honestly and directly in therapeutic than in ordinary social groups. The therapeutic group therefore offers both incentive and opportunity for testing attitudes with respect to present social reality and for facilitating the correction of inappropriate ones.

This discussion may be illustrated by the following two examples of corrective emotional experiences occurring in therapeutic groups, in which the factors of support, stimulation, and reality testing were involved.[4]

[4] The examples are in the form of situation analyses. This way of organizing the data takes into consideration that therapeutic processes are best understood in relation to their total context. The

EXAMPLE 1

Setting.—This 17th meeting was attended by 3 women and 3 men all with neurotic illnesses. Most of the members had learned to express their feelings directly, although there was still a tendency to soften their expression. Jones, a middle-aged, twice-divorced biologist, complained chiefly of a deep feeling of isolation from others and of his emotions being "dead" and "frozen." He had a high degree of social facility and charm and tended to dramatize himself to conceal his lack of real feelings. As he put it, "My whole damn life is an act." He complained that he was compulsively pleasant to everyone, although he was deeply contemptuous of most of humanity. He had had several years of individual psychotherapy in the course of which he had traced these feelings to early experiences with his family. As he put it: "I was trained to pick people apart and do everything on earth to show them up as wrong and then deny it." His mother prized rationality above all else, admired him chiefly for his intellectual cleverness, and would indulge only in what he called "smart talk." He longed to participate in "small talk," but felt that he could not find the words.

In the group Jones had for the most part maintained an air of polite superiority, spiced occasionally with subtly derogatory reactions that appeared to be attempts to provoke others. He felt especially challenged by Mrs. Smith, a southern lady with great poise, who, as he said, was always "safe" and gave him no opportunity for attack. He had, however, succeeded in shocking her deeply a few meetings earlier by frank discussion of some sexual difficulties. The antagonism between them had continued to smoulder without finding direct expression. Another participant in this episode was Mrs. Robinson, a new member, also socially facile, but with quite a barbed tongue. This meeting had been constrained and there had been much "small talk" of the type that disturbed Jones. Except for one perfunctory attempt to draw Mrs. Smith out about her feelings to her mother (who was visiting her), which Mrs. Smith had typically parried with pleasant circumstantiality and pat formulations, Jones had remained silent, but looked increasingly angry. Eventually he joined in a conversation between Mrs. Smith and Mrs. Robinson as to how they spent their spare time by mentioning that he could either bury himself in a detective magazine or do some domestic work like washing his socks. The others ignored this. A few minutes later, Jones, red in the face, said he was as mad as could be at his inability to make small talk like the others. He added that it felt wonderful—he could feel himself tingle inside. The group continued their small talk in the course of which Mrs. Smith and Mrs. Robinson discussed the cleverness of their sons.

Event.—Jones, who had continued to glower, suddenly said that no one in the group except the doctor understood him. Mrs. Robinson retorted that even if he didn't have children he should be interested in them. Jones said he had a child who meant nothing to him and flashed out, "What you say is of no interest to me. I have contempt for all of you; you're all stupid!" He then sank back, as if nonplussed by his own directness.

Effects.—The others agreed matter-of-factly that they were not as intelligent as he, leading Jones to say, "I don't really think you're stupid. I'm angry at your ability to get along and understand one another. I can't. I'm really the stupid one. I'm always isolated. Others can make small talk and I can't." A little later he added, "I'm glad I got around to realizing that you aren't all stupid. To hear three or four guys talking small talk is something that has hounded me all of my days." Finally he was able to say of the group members: "I think if I call them stupid they won't like me."

He commented later that the psychiatrist represented his previous psychiatrist and also his mother—only mother and he understood each other and communicated through rational thinking.

At the next meeting he reported that for several days after his outburst he had felt unusually "alive" and clear-headed, though uneasy. He continued to revel in his new-found ability to express his anger at others in the group, and became increasingly able to enter into more direct, emotionally satisfying relationships with other people in his daily life.

Discussion.—This patient's feelings of isolation and anger were stimulated by the group's tendency at this meeting to indulge in small talk, the presence of a woman patient whose poise irritated him, a brief discussion of feelings toward mothers, his vain attempt to join in the small talk by reference to washing his own socks, which only served to humiliate him, and finally mothers in the group bragging about their bright sons. He finally lashed out at the others as stupid, and to his astonishment they accepted this. This was a corrective emotional experience through which he discovered that his compulsive covering-up of his angry contempt for others was not really necessary. He then could see that his anger really sprang from his own sense of isolation—that he was the "stupid" one in his inability to get close to others. After this, he became more able to express his anger without camouflage. It may be surmised also that the willingness of the others to agree that they were not as intellectual as he was might have helped him to discover that people could respect themselves for other characteristics than intellect, which he and his mother had long ago agreed was the only quality that mattered.

EXAMPLE 2

Setting.—This was the 36th meeting of a group of neurotic women. Mrs. Henry had sought treatment because since 1938 she had been through "tortures of the worst punishment in the form

method of comparing reactions in apparently similar situations has proved to be a useful way of deepening and sharpening knowledge of therapeutic processes. Cf. Ref. 3.

of the most obsessive thoughts anyone could have." She had obsessive preoccupations with death, sex, and other matters, in addition to compulsive rituals that seriously interfered with her activities. On certain days she could not bathe or attend to other aspects of personal hygiene. She felt compelled most of the time to wear old ragged clothes, to pick up trash from the streets or out of garbage cans, and to go through elaborate rituals while walking. She presented herself at her initial interview wearing a plain black dress and no make-up. Her hair was stringy and unkempt and her legs were bare and covered with dirt. She talked rapidly and incessantly, describing in minute detail her obsessions, compulsions, and the lengthy psychiatric treatment, including hospitalization, she had received so far, obviously with little benefit. She was the oldest of 4 daughters of an alcoholic, emotionally unstable father and a rigid, quietly domineering mother. As she grew up she became increasingly concerned over her father's withdrawal from her and her mother's favoritism for one of her sisters, but she was little aware of her own hostile feelings, especially toward her mother. She had been increasingly avoided by her friends and spent much time with her mother who had become a "nervous wreck" worrying about her. Through her prolonged contact with psychiatrists she had developed exceptional facility in describing her difficulties in psychiatric jargon that tended to obscure her real feelings. Group therapy was offered to her in the hope that she might have helpful emotional experiences through it. These seemed unlikely to occur in individual treatment because she had become so routinized in it.

Mrs. Henry soon came into open conflict with Mrs. Carnes, who grew increasingly irritated at her constant attempts to hold the floor, attract the doctor's attention, and belittle the importance of other patients' problems as compared with her own. This behavior was in striking contrast to her professed feelings of inadequacy and of consideration for others. Mrs. Carnes, an actress, had sought treatment for almost intolerable feelings of impending disaster that prevented her from performing before other people. She also feared that she was contaminating objects around her, thereby harming others. She lived with her authoritarian mother who constantly criticized her and overtly favored her older sister. This patient had received 7 months of individual treatment at weekly intervals from the doctor conducting the group. She had grown so dependent on the doctor that she was unable to express any negative feelings toward him for fear of losing his support. She felt particularly threatened by Mrs. Henry's attempts to monopolize the doctor's attention and after an initial period of self-control began to criticize her for talking too much and for being unable to control her compulsions. Other members tacitly supported these attacks by not coming to Mrs. Henry's aid. They also tended to avoid her company outside the group meetings. Mrs. Henry felt that the therapist's permissive attitude toward Mrs. Carnes represented antagonism toward herself. The tension between these 2 patients persisted for many group sessions. Mrs. Henry gradually began to talk less and so became more acceptable to the others, but showed no change of symptoms.

The 36th meeting was attended by Mrs. Henry, Mrs. Carnes, and Mrs. Light. A good portion of the time was devoted to casual conversation led by Mrs. Carnes, who described in detail her artistic interests and achievements. Mrs. Henry remained restlessly silent for the most part, occasionally making rather pertinent comments without resorting to her old pattern of interrupting and taking the floor herself.

Event.—Mrs. Carnes, annoyed at Mrs. Henry's remarks, suddenly told her to "Keep quiet and don't talk so much!" The doctor, aware of the inappropriateness of Mrs. Carnes' attack, asked her what she was annoyed about. Mrs. Carnes burst into tears and told Mrs. Henry that she resented her because of her unattractive appearance and could not stand being around her. She then abruptly walked out of the room. The therapist, somewhat startled by this development, decided to go after her and ask her to return, so that things could be thrashed out, hoping in this way to give her support while at the same time implying disapproval of her behavior. She came back and remained silent for the rest of the meeting, which continued to be laden with tension.

Effects.—Mrs. Henry was absent from the next meeting for the first time. The therapist wrote her a note telling her that the group and he had missed her and inviting her to come for an individual interview after the next group meeting. Mrs. Henry came to the next meeting. To everyone's astonishment she wore a colorful dress, was carefully made-up, and had a permanent wave. She seemed cheerful and proudly announced that she had been absent the week before because she had an appointment to apply for a job. The other members seemed perceptibly more cordial and relaxed than before. In the individual interview Mrs. Henry told how elated she felt when Mrs. Light had told her after the meeting that the attack by Mrs. Carnes had been totally unjustified. She also had the feeling that the therapist was on her side for the first time and contrasted his behavior with that of her mother who always sided with the favorite sister, whether she was right or wrong. "I never realized how mad I was at my mother for preferring my sister to me." In this connection the doctor inquired how she felt when he asked Mrs. Carnes to return. She replied that this was reassuring to her because she felt that he would do the same for her (which he had done by writing her after her absence from the next meeting).

Discussion.—Mrs. Henry's tendency to monopolize the conversation had been repeatedly criticized by Mrs. Carnes during the earlier group meetings. She felt, with some justification, that the doctor as well as the group supported Mrs. Carnes in her attacks. When she gradually became less talka-

tive the group as well as the doctor accepted her more, which in turn stimulated Mrs. Carnes' feelings of rivalry toward her. When she was again attacked by Mrs. Carnes, this time without justification, she felt promptly supported by the doctor as well as by another group member. This was different from the situation at home where mother always sided with her favorite daughter. To make sure of the doctor's attitude, the patient stayed away from the next meeting—a very rebellious act for this obsessive person. Instead of reprimanding her, the doctor let her know that he and the group had missed her. It is noteworthy that, until this event, the patient had no conscious awareness of hostile feelings toward her mother or of rivalry with her sister. After this emotional experience, she no longer felt herself to be as much in the role of Cinderella, as shown by her improved appearance. Mrs. Carnes showed beneficial effects also. For the first time she rebelled against the therapist by running out of the meeting, but in contrast to mother he did not rebuke her. As she became more assertive with the therapist, she began to be less competitive with the other group members.

DISCUSSION

In both examples, the setting in which the intense emotional experience occurred was very familiar to the patient. Mr. Jones was excluded from the conversation of others. Mrs. Henry was criticized for talking too much and for her slovenly appearance. The situations, however, had a different outcome from those in their daily lives. Mr. Jones instead of hiding his feelings under an affable exterior was able for the first time to express them openly and to his astonishment found them acceptable to the others, instead of leading to their rejection of him. Mrs. Henry found that others came to her defense. That is, the patients discovered that some resolution of the situation other than the usual or expected one was possible. This was followed by a change of behavior accompanied by increased insight. Mr. Jones saw clearly that the difficulty lay in himself, not in the stupidity of others, and Mrs. Henry became more aware of her anger at her mother. Mr. Jones remained able to express his feelings more honestly and directly. Mrs. Henry started to look after her personal appearance. These examples then would seem to represent genuine corrective emotional experiences in that they disrupted habitual patterns of thought and action and gave new ones a chance to form.

Support, stimulation, and reality testing formed an integral part of the process. Mr. Jones' feeling of isolation was stimulated by the ability of the other patients to relate comfortably to one another. He would probably not have been able to express his hostility had not previous experiences in the group led him to believe that he could do so safely, which was confirmed by the accepting attitude of the others when he attacked them. The real life quality of this acceptance heightened its effectiveness and showed him how distorted his perception of others had been.

The role of stimulation in Mrs. Henry's case is obvious—she was directly attacked. Strong support was forthcoming from another patient and the doctor, which gained additional effectiveness from the fact that it occurred in a situation similar to ones that the patient had experienced many times before at home but without such support.

Neither of these experiences could have occurred in individual therapy. Mr. Jones could talk about his feelings toward stupid people in individual treatment, but could not directly experience them, since the doctor was by his definition not stupid. He also lacked the opportunity to express his feelings to them in a treatment situation in which he could experience and examine the reaction of the others. Only in the group could Mrs. Henry find someone to play the role of her sister, that is, someone with whom she felt in competition and who provided the stimulus for change by her direct attack. The individual interview also could not give her the additional support that she obtained from another group member.

These two examples illustrate favorable outcome of emotional experiences in therapeutic groups. It is not implied that this is always the case. Emotional reaction in groups or elsewhere may be traumatic as well as helpful. Patients have been driven from groups by adverse stimulation and lack of support, especially since these tend to be heightened by the real-life quality of the experience. The aim of dynamically oriented group therapy is to facilitate useful functions of group situations, while minimizing the potentially unfavorable ones.

SUMMARY

The parts played by stimulation, support, and reality testing in the corrective emotional experience that constitutes the essence of psychotherapy are discussed and illustrated by 2 examples from group psychotherapy, which could not have occurred in individual treatment.

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RELAXATION METHODS IN U. S. NAVY AIR SCHOOLS [1]

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In 1943 reports from flight instructors at primary naval training stations indicated that many cadets seemed fatigued, restless, sleepless, and apprehensive. While still making adjustments to navy life and discipline they were apparently unable to relax. States of excessive tension while learning to fly came to be recognized as a menace. Likewise, reports from the combat zones indicated that under critical conditions, including fatigue, one of the chief difficulties with which pilots had to contend was failure to relax. In part at least, high tension seemed responsible for loss of pilots and planes on first missions involving combat.

Interviewed on February 26, 1943, concerning operations in the Guadalcanal area, Lt. Cmdr. LeRoy C. Simpler, U.S.N., stated that, after 5 days or more of intensive action, flyers often began to manifest loss of weight, digestive disturbance, tremor, and continued irritability. Such debilitating effects, he believed, could render a veteran squadron less effective than even a relatively inexperienced group in a well rested state.

To learn more about states of high nerve tension and fatigue at the Pre-Flight School, Chapel Hill, North Carolina, Drs. William L. Woods and Lucien Brouha of Harvard University observed cadets of the 23rd, 24th, and 38th Battalions before and after a period of approximately 8 weeks of ordinary preflight training. Many cadets reported "a feeling of being tightened up," others a period of tossing about before going to sleep. Some appeared continually overactive or restless. Such symptoms often preceded or accompanied fatigue. The syndrome was designated "fatigue-tension." The examiners employed a 4-point rating scale in recording their observations concerning fatigue-tension: "4" indicated no manifestation; "3" slight; "2" moderate; and "1" marked. Since the ratings shown in Table 1 merely summarize the clinical impression of the examiners regarding each cadet, no mathematical accuracy can be attributed to the figures. However, they are presented for their qualitative value.

These figures suggest that possibly somewhat less than half of the cadets showed moderate or marked manifestations of fatigue-tension.

Concerning subjective experiences at the 5 preflight schools, 3,181 cadets answered a written questionnaire. They had received at least 8 weeks of regulation preflight training. To permit complete freedom, they were instructed not to sign their names. The questions were to be answered by "yes" or "no" or "excessive" or "moderate" or "none." Because of limitations of space, I quote only 8 of the 22 questions, including the results.

TABLE 1

OCCURRENCE OF FATIGUE-TENSION

Fatigue-tension rating	Number of cases	Percentage
1	33	9.3
2	117	33.1
3	55	15.5
4	149	42.1
Total	354	100.0

No quantitative value pertains to the results secured from any such questionnaire. However, the percentages as between the various 5 schools revealed a fair measure of agreement. We note the shortcomings of the questions, the subjective character of the answers, and the diverse interpretations of the same question doubtless made by different cadets. Nevertheless, some significance can be attached to the conclusion that most of the cadets reported nervous difficulties of one sort or another.

[1] This article has been submitted to the Bureau of Medicine and Surgery, Department of the Navy, for official clearance, with the following endorsements: "Review of this material does not imply Department of Defense indorsement of factual accuracy or opinion" and also: "No objection to publication on grounds of military security. Office of Public Information, Department of Defense." (The letter stamp was dated 23 March 1951.) The opinions or assertions in this article are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or of the naval service at large.

QUESTIONNAIRE 1

Questions	Per cent	Replies: Yes	Replies: No
1. Upon retiring at night do you have trouble going to sleep?			
Excessive	5		
Moderate	31		
None	64		
2. While in bed at night do you make frequent shifts or fidgets?		39	61
3. After a night's sleep do you ever feel tired upon arising?		76	24
4. Have you a tendency to worry about events of the next day?		43	57
5. Previous to athletic contests have you ever become sick in the stomach?		11	89
6. Do you ever worry about your own health?		37	63
7. When you hear a sudden noise do you jump or feel startled?		29	71
8. During periods of degrees of nervousness do tense feelings tend to make your mind confused?		36	64

Training Course for Officers

The relations of restlessness, insomnia, and fatigue as well as of attitudes of apprehension and fear to states of neuromuscular tension have been investigated by Dr. Edmund Jacobson. He has shown that these symptoms and syndromes may be considerably diminished or eliminated by methods of progressive relaxation(1). He found also that relaxation methods are readily adaptable for group teaching. Accordingly when the physical training section instituted a training program for the relief of nervous symptoms and fatigue, the methods introduced by Jacobson were employed. According to Jacobson the states of neuromuscular tension can be measured in intact man in action-potentials. Thus he accomplishes direct measurement of what are known as psychosomatic states of nervousness and excitement.

In physiological terms, relaxation as applied to muscles means muscular limpness —the lengthening of muscle fibers that occurs upon inactivity. Likewise, as applied to nerves, relaxation means the direct opposite of activity. Jacobson has determined the extent of relaxation by means of electrical instruments capable of very low voltage measurements(2). Since approximately one-half of the nerves of the body extend to and from muscles that they supply, it becomes obvious that any procedure that induces muscular relaxation necessarily brings with it reduced activity of the sensory and motor nerves of the muscles relaxed and of the corresponding regions of the central nervous system (including the brain) that control muscular states.

The course in relaxation training was introduced during the earlier part of the Naval Aviation Pilot Training Program. From each of the 5 preflight schools an officer was selected. These officers received intensive training for 5 weeks in Jacobson's Laboratory for Clinical Physiology. Under the direction of Jacobson, they formulated a training program for cadets and in turn gave instruction to 95 other naval officers. The total of 100 officers trained approximately 15,000 cadets in 8 months.

The course of instruction by Jacobson to the instructors required about 10 hours per day, distributed approximately as follows:

1. Each officer was trained to relax in 3 one-hour periods per day at intervals.

2. Each officer was tested for his progress in relaxation by action-potential measurements and received additional instruction during some of the tests.

3. Lectures were given by Jacobson on the physiology and psychology of states of fatigue, nervous irritability, and excitement in their relationship to naval aviation training for combat. Psychosomatic problems that arose in the experience of the officers were likewise considered.

4. Each officer practiced alone at least 2 hours per day.

5. Since these men were accustomed to daily vigorous activities, at least 1 or 2 hours per day were devoted to athletic exercises.

Training Course for Cadets

1. Cadets in the preflight schools were trained to some extent to recognize tensions in skeletal muscle groups, and to some extent

to relax them at will. Classes included up to 300 members. The largest classes were supervised by about 5 officers.

2. Cadets were trained toward going to sleep quickly and easily under difficult conditions.

3. An attempt was made also to train cadets to recognize their individual patterns of tensions under the stress and strain of the aviation course, and upon recognition of these specific tensions to relax them as promptly as possible without stopping to lie down.

Unfortunately, the instruction had to be limited to 3 half-hour periods per week for 10 weeks. Jacobson prescribes a course of training on the order of 150 hours of instruction. In addition, the learner is expected to practice by himself at least 1 hour per day. Admittedly, the cadets did not as a rule fulfill these requirements.

Results

1. Injuries and Absenteeism.

Some influence of the relaxation training possibility can be inferred from the percentage of injuries and of resultant days of absence from physical training activities at preflight schools. Many of these activities were competitive. Records from the preflight school at Iowa City concern 4 battalions, with a total of 1,221 cadets. The number of cadets used in control tests was far smaller than those who received relaxation training, making it difficult to draw conclusions with quantitative accuracy.[2]

Of the 70 days during which all cadets were scheduled for participation in physical training activities, the total number of injuries in the control group of 238 cadets was 87, while that in the battalions that received relaxation training (983) was 29.6. As shown in Table 2 the number of injuries per cadet was 0.37 in the control group, which fell to 0.30 in the test group, a reduction of about 19%.

TABLE 2

Injury Report from Preflight School, Iowa City

	No relaxation training (238 cadets)	Relaxation training (983 cadets)
Strains	24.	66.
Sprains	44.	137.
Dislocations	7.	11.
Fractures	6.	29.
Misc. (cuts, bruises, etc.)	6.	53.
Total injuries	87.	296.
Injuries per cadet	0.37	0.30
Percent reduction	..	19.

In the same groups (Table 3), the total number of days lost from injuries was 1.05 per cadet in the control group, but 0.65 in the group that received relaxation training, a reduction of 38%.

TABLE 3

Report of Days Lost from Injuries from Preflight School, Iowa City

	No relaxation training (238 cadets)	Relaxation training (983 cadets)
Days lost from injuries	249.	635.
Days lost per cadet	1.05	0.65
Percent reduction	..	38.

2. Athletic Achievement.

The cadets of 12 battalions that had finished the brief course in relaxation training were compared with those of 12 other battalions without such training. In Table 4 the data are given from 3 of the preflight schools in which these cadets were stationed.

TABLE 4

Athletic Achievement of Cadets With and Without Relaxation Training

	Initial test		Final test		Improvement	
	No relax	Relax	No relax	Relax	No relax	Relax
Chins	7.93	8.16	9.73	9.70	1.80	1.54
Push-ups	24.47	25.32	28.87	29.60	4.40	4.28
Jump reach	21.84	21.94	22.39	22.37	0.55	0.43
Speed agility	32.66	32.53	31.64	31.18	— 1.02	— 1.35

These figures show no marked differences between the test and control groups. However, it should be noted that the cadets who received relaxation training sacrificed 1½

[2] Report by Lt. Comdr. Fred Stalcup, preflight school, Iowa City, Iowa, 1944.

hours per week of time devoted by the cadets of the control group to practice in the conditioning program. Perhaps the only conclusion that can be safely drawn is that, notwithstanding the loss of time from physical training, the relaxation program did not retard the physical conditioning of the cadets.

Swimming grades of 2 battalions who had received relaxation training were compared with those of 3 other battalions under similar conditions, but without training to relax. On the average the cadets with relaxation training passed 20% more tests over a scheduled period than the cadets who did not have such training.[3]

3. Sleep Check.

A "sleep check" was carried out at 3 of the preflight schools.[4] At night, from taps to reveille, cadets were observed in their rooms, which were lit dimly. Each officer observed from 4 to 8 cadets, keeping individual records.

The cadets, 340 in number, were observed in 3 preflight schools during their ninth week at these schools. Of these, 190 were without relaxation training while 140 were trained in 26 periods, each of 30 minutes.

Since observations were made under the same conditions, presumably the presence of officers and a low light in the room did not affect one group of cadets more than the other.

For each cadet the following items were recorded: (1) length of time from taps to apparent onset of sleep, (2) number of times and length of time awake during the night, (3) total loss of sleep in minutes, and (4) dreaming.

Hourly records were kept of full body turns; number of parts of body movements: *e.g.*, moving leg, swinging arm, etc.; and talking or mumbling in sleep.

Some of the cadets who had no relaxation training made some surprisingly restless records. One cadet made 41 body turns. Another moved parts of his body 132 times during the night. A third talked or mumbled 16 times. At Del Monte a cadet awoke 6 times during the night. Another cadet from the same school failed to sleep 2 hours and 34 minutes of the night. No such examples of severe restlessness were noted in the individuals who had received the training.

TABLE 5

SLEEP CHECK SUMMARY

Combined Data from 3 Preflight Schools

Average for cadet	No relaxation (190 cadets)	Relaxation (140 cadets)	Difference %
Time from taps to sleep, in min	22.7	15.4	32
Total loss of sleep, in min	31.5	18.9	40
Number of times awake	.71	.32	55
Dreaming	.28	.20	29
Full body turns	12.0	8.8	27
Part body movements	31.2	22.4	28
Talking or mumbling	2.70	1.20	56

Results are summarized in Table 5.

Talking and mumbling were reduced to the greatest extent (56%). The number of times cadets awoke during the night was also reduced by over one-half (55%). The percentage of complete body turns and of shifts of parts of the body showed the least difference (27% and 28% respectively)(3).

Of the 7 percentages shown in Table 5, each exceeds 25% and the average is approximately 38%. The results indicate that for the most part the cadets after relaxation training became able to go to sleep more quickly, were less restless during sleep hours, and lost less sleep.

During the last part of the night in cadets without relaxation training, bodily movements, including both full body turns and parts of body movements, were greatest. During the last 2 hours cadets with relaxa-

[3] Report on swimming grades was furnished by Lt. Comdr. J. Smith, Officer in charge of swimming, preflight school at Del Monte, California.

[4] "Sleep checks" were made at preflight schools in Athens (Officer in Charge, Lt. Comdr. R. S. Warren), Del Monte (Officer i/c, Lt. Comdr. Wm. Neufeld), and St. Marys (Officer i/c, Lt. Comdr. F. M. Ingram), January 1944.

tion training rested more quietly in respect to bodily movements.

In both groups the period of greatest restlessness was between 0200 and 0300, including talking and mumbling. From the results it would seem that the most restful sleep occurred during the first 2 hours of sleep, which were before midnight. The results indicate that cadets who received relaxation training slept much more quietly.

4. Cadet Reaction to Relaxation Training. Obviously, in any teaching program, the reaction of the pupil, favorable or unfavorable, is of great importance, for it is likely to determine the extent to which he makes use of what he has learned. Accordingly, questionnaire methods were employed to learn something about the emotional reaction and the opinion of the cadets concerning the relaxation training periods. It was not proposed to secure from these opinions any measure or objective determination of the changes possibly effected by the training program, but only to learn something about their individual psychological reaction to the program.

At 4 of the preflight schools, 3,238 cadets were requested to fill out questionnaires after having completed the relaxation training.[5] In order to ensure free expression of opinion, they were instructed to omit their names. Following are the 12 questions presented, including the percentage of affirmative and negative replies. Because of limits of space, I omit their comments, which often stated in detail how they made use of relaxation methods during studying and athletic activities as well as other duties.

QUESTIONNAIRE 2

Questions	Replies, per cent: Yes	No
1. Have you noticed any improvement in your ability to get to sleep quickly?	83	17
2. Have you noticed any improvement in your ability to stay asleep throughout the night?	68	32
3. Has your sleep been more restful?	77	23
4. Has the relaxation course helped you in academic subjects? Explain	71	29
5. Have you noted improvement in any phase of athletics?	66	34
6. Has this experiment helped you in code, blinker or military?	70	30
7. Comment on what you think of this relaxation course: Favor it..... 99% Not interested..... 1%		
8. Has relaxation aided you in preparation for contest, bout, or examination?	85	15
9. Has relaxation aided you during contest, bout, or examination? If so how?	78	22
10. Has relaxation affected your nervousness or "butterflies" prior to contest?	62	38
11. How are you planning to use relaxation during flying? Be specific	97	3
12. Would you like an advanced course in relaxation?	97	3

Summary and Conclusions

1. In 1943 at United States primary naval training stations many cadets (perhaps about half) showed symptoms and signs of restlessness, insomnia, fatigue, and apprehension. Questionnaires filled out by 3,181 cadets at 5 preflight schools in their ninth week of training indicated nervous complaints on the part of most of the cadets.

2. Group methods of instruction were employed with the purpose of reducing nervous irritability and excitement in cadets. In preparation, 5 officers were given a course of instruction in progressive relaxation by Dr. Edmund Jacobson. These officers subsequently instructed other officers, until a total of 100 relaxation officers became available for instruction of cadets. The cadets were taught progressive relaxation in classes numbering up to 300.

3. The course in relaxation for cadets was of 10 weeks duration, consisting of 3 periods per week of ½ hour each. This was an abbreviated course, according to Jacobson's classification, since the total was about 10% of the 150 hours of instruction required in a more thorough course. In addition, the cadets generally did not practice with daily regularity as Jacobson prescribes. Accordingly the following procedures can be regarded as tests of results secured by relaxation methods employed on groups under

[5] Questionnaire 2 was set up by the officers in charge of relaxation training at 4 preflight schools, Del Monte, Athens, Iowa City, and St. Mary's, 1944.

severe limitations, rather than tests of what could have been accomplished under more satisfactory conditions.

4. Tests at the preflight school at Iowa City on 983 cadets who had received such relaxation training indicated approximately 19% reduction of strains, sprains, fractures, and other minor injuries in the test group as compared with a control group.

5. Tests on these same groups revealed a 38% reduction of days lost from injuries. Since the control group was considerably smaller than the test group, no quantitative accuracy can be attached to these figures but they would seem to indicate that on the whole a noteworthy reduction of injuries and of days lost from injuries was probably accomplished by the relaxation training.

6. In 3 preflight schools data were secured concerning the rest in bed of 140 cadets who had received relaxation training as compared with 190 cadets without training. Marked increase of quietude, recorded in percentages as from 27 to 56, occurred in the number of full body turns, parts of body movements, and of talking or mumbling. The reports suggested a marked diminution in dreaming. Figures for the total group indicated that the cadets who had received such relaxation training went to sleep more quickly on the whole and suffered less from insomnia during the night.

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DIAGNOSING MENTAL DEFICIENCY IN PSYCHOTICS[1]

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Despite the tremendous amount of literature on the question of differential diagnosis in psychiatry, there is relatively little information available as to the criteria for a diagnosis of psychosis and mental deficiency. Most of the reports, such as those by Hunsicker(1), Pearson(3), and Whitten(6), present case illustrations without being too specific as to the criteria upon which the differential diagnosis was based.

It is more than the satisfaction of academic curiosity that requires the establishment of the correct diagnosis in such cases. The important questions of prognosis and treatment are involved. It is fairly well established that the patient suffering from a psychotic reaction has a better chance for eventual recovery if his intellectual capacity is normal. Upon improvement from his psychotic reaction, he is generally able to leave the hospital and to gain a position in the outside world. In the patient with psychotic reaction and mental deficiency, the prognosis and the anticipated improvement with the presently known modalities of treatment are much poorer. This type of patient is generally unable to make an adjustment outside the hospital even if his psychotic reaction has improved.

The question of eligibility for pension or compensation benefits is another important reason for establishing the proper diagnosis, particularly in veterans where the effect of military or combat service must be carefully evaluated as to its role in the development of the patient's mental illness.

From the point of view of statistical classification, and also as an aid in understanding the etiology of various types of mental illness, how much of mental illness is engrafted upon intellectual deficiency and how much arises in intellectually normal individuals should be determined. Pearson(3) pointed out that during the statistical year ending September 30, 1936, 3.6% of all first admissions to Massachusetts hospitals for mental illness were diagnosed as psychotics with mental deficiency. The percentage of such patients occupying beds in the Massachusetts mental hospitals was more than twice as high, 7.5%, which was explained by the fact that these patients have a lower rate of discharge and remain hospitalized for longer periods.

However, the validity of these figures may be questioned in view of the difficulty in making correct diagnoses in this category. Pearson mentioned that the discharge rate of these patients was 43.7 per 100 admissions, a figure that would appear to be unusually high for psychotics who were mentally deficient as well. On the other hand, Tredgold has given an even higher estimate of the incidence with the statement, "It is probable that at least ten percent of all inmates of mental hospitals in the country are certifiable mental defectives"(4).[2]

In the present study an attempt has been made to review the significant features involved in making the proper diagnosis of mental deficiency and a psychotic reaction, and to present some of the factors that need further attention. The patients studied were those at the Veterans Administration Hospital, Northport, L. I., N. Y., who had been given the diagnosis of psychosis and mental deficiency more than 4 years ago. Although it was recognized previously that many such patients might have been incorrectly diagnosed, nothing could be done at this hospital until sufficient personnel became available to

[1] Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

[2] A related problem involves the misdiagnoses of psychotics as mentally deficients. As Kanner has speculated: "I wonder if some persons who are harbored in institutions for feebleminded are not in reality individuals whose early infantile autism had not been recognized and who abandoned themselves uncompromisingly to idiot-like dysfunction"(2). However, the present paper is limited to those patients diagnosed as both psychotic and feebleminded.

test and re-evaluate all the patients on the continuous treatment service who had carried this diagnosis. There appeared to be no need to investigate such patients on the acute intensive treatment service since all questionable patients on this service had received recent psychological evaluations.

A survey of the approximately 2,000 patients on the continuous treatment service disclosed 28 who were diagnosed as psychotic and mentally deficient. Of the 28 patients, 7 proved to be untestable; that is, the psychological examiners felt that no valid estimate of their intelligence could be obtained through the test results, and a re-evaluation of their clinical case histories proved indecisive. No attempt has been made in this paper to discuss or become involved in the differentiation between the diagnosis of a psychotic reaction *with* mental deficiency and that of a psychotic reaction *and* mental deficiency. Our primary interest is in establishing whether or not sufficient evidence of mental deficiency exists in these psychotic patients to warrant inclusion of this condition in their diagnostic classification. The original diagnoses and other significant data of the 21 testable patients are shown in Table 1.

The age of the patients ranged from 25 to 60 years. The age distribution followed the bimodal curve usually existing in Veterans Hospitals. There were 5 patients between the ages of 25 and 30, 3 who were in their 40's, and 13 who were over 50 years old. The place of birth was noted to determine whether these patients were misdiagnosed because they came from atypical cultural backgrounds. However, it can be seen that 9 of the patients were born in New York City, 3 others were born in New York State, while only 3 were of foreign birth. There were 14 World War I veterans and 7 who were veterans of World War II.

The educational attainments and occupational levels of all patients were fairly low as would be expected since a high educational or occupational level would contraindicate a diagnosis of mental deficiency. Race was not a factor, with 18 of the patients being white and the other 3 Negro, a proportion fairly typical of the general hospital population. The distribution with respect to religion also corresponded with that of the general hospital population.

In almost all cases, the original diagnosis of mental deficiency was supported by the results of the psychometric examination. This occurred because the standard nomenclature of psychiatric disorders and reactions of the Veterans Administration requires that such an evaluation accompany any diagnosis of mental deficiency. Unfortunately, very little information was generally available as to the details of the test performances. In most of the clinical case records, there was only an announcement of the final score. In half of the records, the name of the test administered was not mentioned.

The first step in the reassessment of these patients involved a review of their clinical case histories. In none of these histories were there any clinically discernable features that identified the reaction as one that characteristically occurs associated with mental deficiency. The episodic types of psychotic reaction with frequent rage manifestations, manic behavior, and periods of confusion and excitement, so often described as distinctive of a psychosis with mental deficiency, were not found in any of these cases. This may have occurred because the study, being limited to veterans, excluded those individuals with the more severe and obvious forms of mental deficiency who would have been screened for military service.

While all the patients had poor educational and vocational background, such information was inconclusive since this would also occur as the result of a psychotic or prepsychotic reaction. The early signs described as pathognomonic of childhood schizophrenia or of other mental illness are reliable only when reported by trained observers. Few parents can detect such features in their children and fewer still are willing to bring them forth so many years later when a question arises concerning the child's early adjustment. Further, the personality description of a patient prepared when he is still a child usually differs very much from that obtained in retrospect 10 or 15 years later after a definite psychosis has developed. Therefore, it was felt that the differential diagnosis had to be made primarily from the results of psychometric examination.

TABLE 1

TESTABLE PATIENTS ORIGINALLY DIAGNOSED AS MENTALLY DEFECTIVE

No.	Age	Place of birth	Education	Occupation	Original diagnosis	Basis of original diagnosis	Obtained W-B IQ	Estimate of basic intellectual level
1.	60	New York City	Finished at 17	Odd jobs	Psychosis with mental deficiency	M.A. 10 yrs. 1 mo.	93	Bright normal
2.	56	New York City	5th grade at 16	Horseshoer	Chronic alcoholism with psychotic reaction, deteriorated type; mental deficiency	Md. M.A. 10 years (Pintner-Paterson)	101	Normal or better
3.	51	New York City	8th grade	Laborer	Psychosis with mental deficiency	Unknown	93	Normal
4.	25	New York City	7th grade at 12	Electrician	Psychosis with mental deficiency	Qualitative opinion that he is a low-grade moron	87	Normal
5.	52	New York City	5th grade at 14½	Clerk	Psychosis with mental deficiency	IQ 48	82	Normal
6.	54	New York City	5th grade	Laborer	Psychosis with mental deficiency	IQ 56.5, M.A. 9 yrs. 1 mo. (1936) 57 M.A. 9 yrs. 2 mo. (1922) (Stanford-Binet)	87	Normal
7.	53	West Virginia	8th grade at 21 (night school)	Woodwork helper	Psychosis with mental deficiency	IQ 40, M.A. 8 yrs. (Kent Test); IQ 77, (Wechsler-Bellevue)	86	Normal
8.	42	N. Carolina	3rd grade	Unknown	Psychosis with mental deficiency	M.A. 8 yrs.	90	Normal
9.	30	Italy	4 yrs. Italy	Baker Seaman	Psychosis with mental deficiency	IQ 71 (Wechsler-Bellevue)	89	Normal
10.	52	New York	5th grade at 16	Unknown	Epilepsy, idiopathic, manifested by psychotic reaction, deteriorated type; mental deficiency	IQ 71, M.A. 10 yrs. 8 mo. (Stanford-Binet)	90	Normal
11.	49	Pennsylvania	5th grade	Laborer	Dementia praecox, catatonic type; mental deficiency	M.A. 11 yrs. 9 mo.	90	Normal
12.	53	New York City	6th grade at 16	Dishwasher	Psychosis with mental deficiency	IQ 56, M.A. 9 yrs.	78	Dull normal
13.	51	S. Carolina	2nd grade	Bookbinder	Psychosis with mental deficiency	M.A. 8 years	86	Dull normal
14.	60	New York	Bright at school	Truckman	Psychosis with mental deficiency	IQ 55, M.A. 8 yrs. 9 mo.	84	Dull normal
15.	58	Poland	"on & off" in Poland—13	Machinist	Dementia praecox, simple type; mental deficiency	No score, but comment, "Native mental deficiency clearly shown." (Pintner-Paterson)	77	Dull normal
16.	47	Poland	Little until 19 in Poland	Clothing inspector	Psychosis with mental deficiency	Md. M.A. 9 yrs. (Pintner-Paterson)	70	Borderline or dull normal
17.	54	New York City	6th grade at 16	Laborer	Psychosis with mental deficiency	Md. M.A. 9 years (Pintner-Paterson); IQ 72, M.A. 11 years 6 mo. (Stanford-Binet)	Unreliable	Not mentally deficient
18.	25	N. Carolina	2nd grade	Laborer	Psychosis with mental deficiency	IQ 64, (Wechsler-Bellevue)	57	Mental defective
19.	29	New York City	8th grade at 15	Packer	Psychosis with mental deficiency	IQ 50, M.A. 8 years	61	Mental defective
20.	30	Florida	3rd grade at 14 (began at 11)	Busboy	Psychosis with mental deficiency	IQ 60, M.A. 9 yrs. 8 mo.	56	Mental defective
21.	55	New York City	6th grade at 15	Laborer	Psychosis with mental deficiency	Md. M.A. 6 years (Pintner-Paterson)	Unreliable	Mental defective

Since it was thought that the previous psychometric examinations may have been invalid, each patient was retested. As mentioned previously, 7 of the 28 patients proved to be untestable. In 2 others, it was impossible to derive an IQ, but a valid estimate of their intellectual level could be obtained from their test performance. While IQs were found for the other 19 patients, these had to be supplemented by a qualitative estimate of their basic intellectual level since their scores were frequently lowered because of psychotic rather than intellectual factors.

All patients were tested with Form I of the Wechsler-Bellevue Intelligence Scale. This test was used because it is generally considered the best measure of adult intelligence.[3] When additional test information was desired, other intelligence scales, such as the Grace Arthur Point Scale, were administered. The results of the psychological testing disclosed, as can be seen in Table 1, that 17 of the 21 testable patients, or 81%, obtained IQs above the mental deficiency level as defined[4] on the Wechsler-Bellevue Intelligence Scale.

One patient was estimated as "bright normal," another as "normal or better," and 9 as "normal." There were 4 considered as "dull normal," one as "borderline or dull normal," and one who could be characterized only as "not mentally deficient." Thus, the majority of these patients were well above the "mental deficient" level indicating that gross errors in diagnosis had been made.

While clinical material is too meager to permit any definitive judgment as to the cause of the diagnostic error in the 17 patients who proved not to be mentally deficient, several possibilities do suggest themselves. The psychiatrists determining the diagnosis were misled by unreliable or poorly informative clinical histories, and may also have accepted the functioning level of the patient as evidence of his innate ability. Similarly, the psychometrists did not take into account the loss of efficiency due to psychotic impairment, and accepted the obtained IQ as a valid indicator of a patient's intelligence.

The extremely high percentage of diagnostic errors would strongly suggest the need for re-examining all patients who have been given the diagnosis of psychosis and mental deficiency.

It would seem desirable to retest all such patients whose diagnosis has not been established by a test designed for adults, such as the Wechsler-Bellevue Intelligence Scale, and with the test having been administered and interpreted by a qualified psychometrist. Periodic re-examinations should be given to those patients whose results do not clearly indicate whether or not they are mentally deficient, while a definitive diagnosis is held in abeyance.

SUMMARY

The differential diagnosis between a psychotic reaction and a psychotic reaction and mental deficiency is important because of implications regarding prognosis, treatment, and compensation benefits. In 21 patients who had been given the diagnosis of psychotic reaction and mental deficiency, re-examinations have revealed that mental deficiency could be definitely excluded in 17 or 81% of the cases. In view of these results, it would seem desirable that all patients who have previously been given a diagnosis of psychosis and mental deficiency be re-evaluated through a careful review of the clinical case history. Psychometric information should be considered valid only if obtained by a qualified examiner using an appropriate test.

In 7 of 28 patients having the diagnoses of psychotic reaction and mental deficiency, no final conclusion could be reached as to the existence of mental deficiency because of inadequate or unreliable history and inability to test these patients properly. Periodic re-examinations and reviews of such patients are urged to reduce misdiagnoses of this type to a minimum.

[3] A more extensive treatment of the psychological testing is being prepared for publication in a psychological journal.

[4] Wechsler(5) has suggested that a score of 65 or below on his scale is indicative of mental deficiency. He also mentions the possibility of using an IQ standard of 68 in order to include as mentally defective 3% rather than 2.2% of the total population.

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CLINICAL NOTES

SIMILARITY OF CONSTITUTIONAL FACTORS IN PSYCHOTIC BEHAVIOR IN INDIA, CHINA, AND THE UNITED STATES

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In an article by Wittman *et al.* entitled "A Study of the Relationship between Constitutional Variations and Fundamental Psychotic Behavior Reactions" (J. Nerv. Ment. Dis., 108: 470, 1948) it was stated that in the case of psychotics "the average somatotypes agree with the correlation results in defining the cycloid as endomorphic and mesomorphic and low in ectomorphy, the paranoid as predominantly mesomorphic, and the heboid as predominantly ectomorphic." During a trip to the Orient in 1948 and 1949 I was able to secure data on 50 psychotics that indicate that the above results, obtained in the United States, also hold for psychotics in India and China.[2]

The procedure was as follows. Prior to any knowledge of clinical findings I made an estimate, by inspection, of the somatotypes of the psychotics selected by these psychiatrists. After all somatotyping was done, the psychiatric classification of each subject was given to me. The average somatotype was then computed for the subjects as diagnosed according to type of psychosis. The results, compared to data for the United States (furnished by Dr. Phyllis Wittman from subjects in the Elgin Constitutional Study), are as shown in Table 1.

It is evident from this table that the general picture revealed in the Elgin Constitutional Study is very similar to that presented in the Indian and Chinese data. The relative order of component strength is the same in all three cultures for the schizophrenic and paranoid cases; in the cycloids the low ectomorphy and the strong mesomorphy stand out prominently. The only significant difference is the variation in endomorphy in the cycloid cases, and this is clarified with a more detailed analysis of the groups compared.

TABLE 1

SOMATOTYPES ACCORDING TO DIAGNOSIS IN THE UNITED STATES, INDIA, AND CHINA

	United States		India		China	
Psychosis type	Cases	Average somatotype	Cases	Average somatotype	Cases	Average somatotype
Cycloid	31	Endomorphy 4.76	10	3.20	5	2.70
		Mesomorphy 4.68		5.25		4.70
		Ectomorphy 2.12		2.10		2.90
Schizophrenic (excluding paranoid)	57	Endomorphy 3.13	17	2.85	7	3.36
		Mesomorphy 2.61		2.73		3.00
		Ectomorphy 5.21		4.79		4.29
Paranoid	44	Endomorphy 3.25	3	2.33	1	2.50
		Mesomorphy 4.30		4.50		4.00
		Ectomorphy 3.66		3.50		3.50

Dr. Wittman gives data on the above group of United States cycloids (plus 3 additional subjects) when analyzed into subgroups (see Table 2). The depressed cycloids here constitute a large subgroup, while only one such diagnosis occurs for the Indian or the Chinese subjects. Since it is in this group that

[1] Department of Philosophy, University of Chicago; Department of Social Relations, Harvard University.

[2] The data were secured through the help of Dr. Leslie Cheng, Neuropsychiatric Institute, Nanking; Dr. A. S. Johnson, Government Mental Hospital, Madras; and Dr. N. N. Chatterjji, Lumbini Park Mental Hospital, Calcutta.

endomorphy is seen to be stronger than mesomorphy, it is not surprising that endomorphy is higher than mesomorphy in the United States sample of cycloids, and lower than mesomorphy in the case of the Chinese and Indian subjects. If we compare the 4 Indian subjects diagnosed as mixed cycloid with the 8 United States subjects so diagnosed, the apparent difference between the data for cycloids in the United States and in India largely drops away (see Table 3). None of the 5 Chinese subjects was diagnosed as mixed cycloid, so no comparison with the mixed cycloid group in the United States or India is possible.

TABLE 2

SOMATOTYPES ACCORDING TO SUBGROUP OF CYCLOID DIAGNOSIS.

Cycloid type	No. of cases	Average endomorphy	Average mesomorphy	Average ectomorphy
Manic	11	4.73	4.90	1.86
Depressed ...	15	4.87	4.42	1.98
Mixed	8	4.53	4.92	2.54

TABLE 3

SOMATOTYPES IN MIXED CYCLOID TYPE.

Mixed cycloid type	United States		India
.....	Aver. endomorphy ..	4.53	4.62
	Aver. mesomorphy ..	4.92	5.00
	Aver. ectomorphy ..	2.54	1.25

The relative absence of ectomorphy and the noticeable presence of mesomorphy in the Oriental cycloids is evident if we look at the Chinese and Indian data in another way. Of the 15 cycloids, 12 were predominantly mesomorphic, 2 were predominantly endomorphic; 1 was equal in endomorphy and mesomorphy; none was predominantly ectomorphic. Of these 15 cycloids, 10 were diagnosed as manic and 1 as depressed.

In the case of the Oriental schizophrenics (excluding the paranoid schizophrenics) the situation is reversed: predominantly ectomorphic physiques are common and predominantly mesomorphic physiques are rare. Thus of the 24 subjects, 17 were predominantly ectomorphic, 5 were predominantly endomorphic, and 2 were predominantly mesomorphic.

Of the 4 subjects diagnosed as paranoid, 3 were predominantly mesomorphic, and 1 was predominantly ectomorphic.

The paranoid schizophrenics among the Oriental subjects were less mesomorphic than the paranoids and less ectomorphic than the schizophrenics. Of the 7 subjects diagnosed as paranoid schizophrenics, 4 were predominantly ectomorphic, 2 were equal in ectomorphy and mesomorphy, and 1 was predominantly mesomorphic. None of the 11 subjects diagnosed as paranoid or paranoid schizophrenic was predominantly endomorphic.

Since the number of cases from the Orient is small, and since the somatotyping of the Chinese and Indian subjects was on the basis of inspection and not from the standardized photograph used by Dr. Sheldon, exactitude cannot be claimed for the comparison here reported. But the evidence, such as it is, indicates a constitutional similarity in the psychotics of the United States, China, and India, and suggests the desirability of serious scientific work in comparative psychiatry.

The correlations between my estimates of the constitutional components and those of Dr. Sheldon (made on 50 photographs in his *Varieties of Delinquent Youth*) were as follows: .82 for endomorphy; .87 for mesomorphy; .93 for ectomorphy. My ratings for endomorphy were in general somewhat lower than those of Dr. Sheldon. A correction for this difference would bring our numerical results even closer together. Nevertheless, it is certain that my Chinese and Indian subjects were definitely lower in endomorphy than the American subjects. I have found this also to be the case in a study of a much larger group of university students.

THE SENSORIUM IN DELIRIUM TREMENS AND ALCOHOLIC HALLUCINOSIS[1]

PHILIP F. DURHAM SEITZ, M. D., INDIANAPOLIS, IND.

Although alcoholic hallucinosis is classified as a psychosis due to alcohol in the Standard Nomenclature of Disease and Operations, there is some inclination among psychiatrists to consider this disorder a functional rather than a toxic psychosis. If this were true, one would expect that the sensorium in alcoholic hallucinosis would be less impaired than in a toxic psychosis such as delirium tremens. On this hypothesis, the following investigation was conducted.

The medical records of 49 patients with diagnosis "delirium tremens" and 32 patients with the diagnosis "alcoholic hallucinosis" were selected randomly. Data pertaining to examination of the sensorium were collected from each such hospital chart. Fairly complete information was available regarding the following items: memory, orientation, intellect, judgment, and insight. Each of these sensorial categories was given a rating of "good," "fair," or "poor." The accompanying table summarizes the results.

The percentages for delirium tremens and alcoholic hallucinosis are very similar in all 15 comparisons. The largest variation is found in the "poor judgment" category, and even here the difference is only 7%. The standard error of the difference between these 2 proportions was found to be 12%, indicating that the actual difference is not statistically significant. It is reasonable to assume, therefore, that none of the small differences seen in the table is statistically significant.

TABLE 1

COMPARISON OF SENSORIAL FUNCTIONS IN DELIRIUM TREMENS AND ALCOHOLIC HALLUCINOSIS

	Good		Fair		Poor	
	D. T.	A. H.	D. T.	A. H.	D. T.	A. H.
	%	%	%	%	%	%
Memory	28	28	15	16	57	56
Orientation	50	47	20	19	30	34
Intellect	9	10	33	34	58	56
Judgment	4	3	25	19	71	78
Insight	19	16	38	40	43	44

The results of this study fail to confirm the hypothesis that the sensorium in alcoholic hallucinosis is less impaired than in delirium tremens. It would appear, therefore, that the degree of sensorial impairment does not differ significantly in delirium tremens and alcoholic hallucinosis. This evidence suggests either (1) that alcoholic hallucinosis is a toxic psychosis, having the same degree of sensorial impairment as delirium tremens, or (2) that clinical psychiatric examination cannot be relied upon to differentiate the extent of sensorial impairment in these 2 diagnostic categories.

[1] From the Division of Psychiatric Research, Department of Neuropsychiatry, Indiana University Medical Center, Indianapolis, Indiana, and the Indianapolis General Hospital.

Acknowledgment is made for the generous support of the Indiana Council for Mental Health.

THE PRESIDENT'S PAGE

My dear Colleagues:

Within the next few months, the members of the Association will have the opportunity of voting by mail on certain proposed amendments to the by-laws which were approved during the annual meeting in Cincinnati. One of these proposed amendments would create an Assembly of representatives of District Branch Societies at such time in the future as eight District Branches will have been established. The sole function of this Assembly would be to consider and advise Council on matters referred to it by that body. The proposed amendment also provides that when the representatives of the Affiliate Societies wish to have the privilege of the floor without vote at Council meetings, they shall select from their number a committee of not more than three for this purpose: When a matter of special importance arises, in which the members of a given Affiliate Society desires to have the views of the Society individually presented before the Council, permission shall be sought from the Moderator of the Council for their representative to have the privilege of the floor without vote.

The purpose of this proposed amendment is that with the rapid growth of the Association and the strengthening of its central administration, there must follow a proportionate growth and strengthening of its regional functioning. This proposed amendment to the by-laws would eventually grant a privilege to the District Branch Societies which would not be accorded to the Affiliate Societies. The reason for making this distinction between regional organizations is that the Affiliate Societies are multidisciplinary in their membership, whereas the District Branch Societies are composed exclusively of members of the Association.

Some concern has been expressed that this proposed amendment is a preparation for further steps which will discriminate against Affiliate Societies. To the best of my knowledge, this is a quite unwarranted misgiving. Concern has also been expressed that this proposed amendment would create pressures upon Affiliate Societies to become District Branch Societies. The merits of this question cannot be decided at this time, although free discussion is invited so that a representative democratic action may be taken.

It is the hope of the officers and the Council and those who are interested in this addition to the by-laws that the entire membership will give this proposed amendment close attention. To this end, advance copies of the proposed amendment have been mailed to all regional societies to encourage deliberation and discussion. All members are urged to express their opinions by the mail ballot so that a wide representation will be obtained.

I wish to thank the officers and members of the Association who have worked hard on these plans to encourage the widespread membership of the Association to become more active.

Leo H. Bartemeier, M. D.

COMMENT

RIGHTS AND DUTIES

Further to comment on this subject in the October 1950 issue of the JOURNAL, we quote, with his permission, from a letter of Chancellor Harvie Branscomb of Vanderbilt University.

The United States Office of Education in Washington had sent a form letter to educational institutions throughout the country requesting them to give publicity to the Universal Declaration of Human Rights that had been drafted by a commission of the United Nations (chairman, Mrs. Franklin D. Roosevelt).

Replying to Earl J. McGrath, Commissioner of Education, Washington, Chancellor Branscomb said:

> I presume that you are merely carrying out the responsibilities of your office in pushing this Declaration. May I say, however, that the Declaration is an immoral document. It lists six pages of rights for "everyone" with only a brief, vague, and almost apologetic reference at its close to duties to the community. The demand for rights, however, is detailed, specific, and extensive . . . . without the slightest reference to any obligations involved.
>
> I call the document immoral because morality chiefly consists in the assumption of obligations and duties to others by every individual. To insist on twenty-nine articles of rights which everyone is encouraged to expect from others, without a comparable insistence upon obligation, is merely to advertise the moral weakness of our times. . . . . I would have thought that so wise and distinguished a Commission would have added to this long list of rights, including that of an adequate standard of living, the phrase "provided the individual endeavors to render to society such services as are within his capacity."
>
> This document may be good politics, but those like yourself in high and responsible office need to give attention to developing a sense of obligation in this America of ours in addition to the universal cry for "my rights."
>
> Your letter offers to send material advertising this Declaration of Human Rights. Do you have available also something that promotes a sense of social obligation and public duty?

Instead of publicizing the "Declaration," a copy of Chancellor Branscomb's letter was sent to each alumnus of Vanderbilt University by the president of the Alumni Association.

For the record it may not be irrelevant to recall another clamor for rights that was raised 164 years ago, at the time when the United States was coming into existence. When the draft of the proposed Constitution had been submitted to the legislatures of the several (13) states for ratification or rejection, opponents of the Federal Government raised the cry that the constitution as submitted contained no "bill of rights." Alexander Hamilton dealt specifically with this argument in one of the last issues of *The Federalist* (1788). He pointed out that the Federal Government would have only such powers as were vested in it by the Constitution, and that to draw up and prescribe a list of rights would be merely to say that the government should not do certain things which in fact it had been given no power to do. Bills of rights, he said, "would contain various exceptions to powers not granted. . . . . For why declare that things shall not be done which there is no power to do." Hamilton made prophetic reference to abuses that might attend "the indulgence of an injudicious zeal for bills of rights." And he concluded, "The truth is, after all the declamations we have heard, that the Constitution is itself, in every rational sense, and to every useful purpose, A BILL OF RIGHTS."

Was Alexander Hamilton perhaps gauging the mental processes of future peoples and potentates by the high principles that had guided the Founding Fathers—such principles as Washington personified when in the Federal Convention over which he presided he challenged, "Let us raise a standard to which the wise and honest can repair."

Finally it is assuredly not irrelevant to observe that the question of the balance between rights and duties is crucial to any theory of socialized medicine. Commenting editorially on a report of the committee on social security of the World Medical Association, the *British Medical Journal* (June 2,

1951) says: "It was pointed out that anything in a medical service under a social security scheme which lessened the patient's sense of responsibility heavily increased that of the doctor, and that where the citizen was given increasing rights to this and that benefit he tended to think more of his rights than of his duties."

SHORTAGE OF MALE ATTENDANTS AND NURSES IN MENTAL HOSPITALS

As on previous occasions during mobilization of men and women for military service, there is a trend toward an increasing number of vacancies in mental hospitals for qualified male attendants and nurses. This situation is hazardous from a safety standpoint, it seriously retards successful treatment, and it definitely interferes with the health and welfare not only of patients but also of the personnel of the hospitals.

Qualified male personnel should be encouraged to enter and complete hospital nurses' training. Furthermore, special courses should be conducted for all types of male employees for training in basic hospital and emergency procedures.

In this connection, the attention of the military authorities should again be invited to the injustice of keeping graduate male nurses in an enlisted status, while graduate female nurses are granted an officer candidate status. Well-qualified graduate male nurses should no longer be thus discriminated against.

As in the past, mental hospitals with accepted facilities should invite the military authorities to detail enlisted men for a definite period for training in medical and surgical emergencies, and in hospital procedures. Such opportunities would not only give valuable training for medical enlisted personnel but would also help the hospitals to meet this increasingly difficult situation.

W. C. S.

COMMITTEE ON NOMINATIONS

Fellows and members of The American Psychiatric Association are requested to send to any member of the Committee on Nominations the names of persons they desire to recommend for the consideration of the committee for the offices of President-Elect, Councillors (3), Secretary, Treasurer, and Auditor for the year 1952-1953. The Committee consists of Dr. S. Spafford Ackerly, Dr. Francis J. Braceland, Dr. Henry Brosin, Dr. S. B. Wortis, and Dr. G. H. Stevenson (chairman).

NEWS AND NOTES

CANADIAN PSYCHIATRIC ASSOCIATION.—The provisional directors sponsoring the formation of a Canadian psychiatric association called a meeting at Montreal June 20, 1951, at the same time and place as the annual meeting of the Canadian Medical Association, and announced that the Canadian Government had authorized the incorporation of the association to be known as the Canadian Psychiatric Association.

The president of the Canadian Association, Dr. Norman H. Gosse, presented in person his congratulations and good wishes. Telegrams of felicitation and good will were read from Dr. Leo H. Bartemeier, president of The American Psychiatric Association, and Dr. Clarence Hincks, general director of the Canadian Association for Mental Health.

Officers elected for the year 1951-1952 are as follows: president, Dr. Robert O. Jones of Halifax, Nova Scotia; vice-president, Dr. Charles G. Stogdill of Toronto, Ont.; secretary, Dr. John P. S. Cathcart of Ottawa; treasurer, Dr. R. C. M. Hamilton of St. Anne de Bellevue, Quebec.

The provinces are represented by the following directors: Newfoundland, Dr. G. J. O'Brien; Prince Edward Island, Dr. Alexander J. Murchison; Nova Scotia, Dr. Clyde S. Marshall; New Brunswick, Dr. Robert Prosser; Quebec, Drs. Albert E. Moll and L.-R. Vezina; Ontario, Drs. Kenneth G. Gray and John N. Senn; Manitoba, Dr. Gilbert Adamson; Saskatchewan, Dr. D. G. McKerracher; Alberta, Dr. Randall R. Mac Lean; British Columbia, Dr. Joseph C. Thomas.

PSYCHIATRIC NURSING PERSONNEL.—A booklet with this title has been published by the Mental Hospital Service of The American Psychiatric Association. It contains facts and figures for 1950 concerning patient-personnel ratios, educational programs, responsibilities of nurses and attendants, and personnel policies as they pertain to psychiatric nursing in mental hospitals. The booklet was prepared by Dorothy E. Clark, R. N., nursing consultant to the Committee on Psychiatric Nursing, and is available from the Mental Hospital Service, 1624 Eye St. N. W., Washington 6, D. C., at a cost of 60 cents.

MENTAL HOSPITALS, 1950.—The Proceedings of the Second Mental Hospitals Institute, which took place in St. Louis, Mo., October 1950, are now available. They are entitled "Mental Hospitals, 1950" and constitute a successor to "Better Care in Mental Hospitals," which was published in 1949 and very well received. The new book may be ordered from the Mental Hospital Service of The American Psychiatric Association at a cost of $2.50.

DR. RICHARDS RECEIVES DEGREE OF D. SC.—Dr. Esther Loring Richards, associate professor of psychiatry at Johns Hopkins University and consulting psychiatrist at Baltimore City Hospital, has been awarded the honorary degree of Doctor of Science by Wilson College at its 81st commencement.

President Paul Swain Havens, in conferring the degree, said, "In a world largely preoccupied with perfecting the means of destruction and death you have chosen to perfect the techniques of reconstruction and health, and in so doing you have given an example of what painstaking research coupled with unselfish humanity can do to lighten the burdens of your time."

"NEUROPSYCHIATRY."—Volume 1, Number 1, of this new journal bears the date Spring 1951. While it is described as a quarterly report of the Department of Neurology and Psychiatry of the University of Virginia, it is not limited to contributions from that center. The first issue contains the Proceedings of the Conference on the Treatment of Emotional Disorders held March 23, 1951 and sponsored by the University of Virginia and the Medical Society of Virginia.

Dr. David C. Wilson is editor of *Neuropsychiatry;* the editorial office, Department

of Neurology and Psychiatry, University of Virginia, Charlottesville, Va.

DR. WILLIAM BAILLIE DIES.—With deep regret we record the death on June 15 of Dr. William Baillie of Toronto, whose retirement was announced in the November 1950 Journal. Despite retirement he had continued in full-time professional activity up to and including the day of his death. One of the indications of his value to Canadian military and rehabilitation neurology and psychiatry is the fact that for many years he was consultant referee to the Board of Pensions Commissioners, to whom difficult and contentious cases were referred, his decision being accepted as final. He was at work at Sunnybrook Hospital when stricken.

GROUP PSYCHIATRY IN PRIVATE PRACTICE.—The Commission on Group Psychotherapy in Private Practice of the American Group Psychotherapy Association is making a survey of the extent to which group psychotherapy is used in private practice.

Some material has already been collected about the various forms of group psychotherapy used. It has been planned to devote one session of the 1952 annual meeting of the Association to the private practice of group psychotherapy. All those using the method in private practice are invited to participate in the study; they should write to Dr. Wilfred C. Hulse, 110 W. 96th St., New York 25, N. Y.

PSYCHIATRY FOR GENERAL PRACTITIONERS.—The third annual postgraduate course on psychiatry for the general practitioner was held at the University of Colorado Medical Center July 26-28, 1951. The practical nonspecialized aspects of psychiatry in general medicine were emphasized. Dr. Burtrum C. Schiele, professor of psychiatry at the University of Minnesota, was guest lecturer, and 24 members of the faculty of the University of Colorado School of Medicine also participated.

SWISS SOCIETY FOR PSYCHIATRY.—The 115th meeting of the Swiss Society for Psychiatry was held June 9 and 10, 1951 in the Mental Hospital Herisau (Canton Appenzell) and the Commercial College in St. Gallen.

The topic of the meeting, at which Dr. Wyrsch presided, was "Further Development and Legal Problems in Institutional Psychiatry." Leading reports were presented by Dr. Manfred Bleuler and Dr. Henri Bersot. Drs. André Repond, Heinrich Künzler, and J. H. Staehelin also read papers referring to the main topic.

On the second day Federal Judge Dr. Paul Lugoz (Lausanne) reported on the legal aspects of professional confidence and Dr. Georg Stutz (Liestal) on the duties of the institutional directors.

The organizing committee of the society and the cantonal administration saw to it that the meeting was stimulating as well as socially enjoyable.

AMERICAN PSYCHOANALYTIC ASSOCIATION.—At the annual meeting of this Association at the Netherland Plaza Hotel, Cincinnati, Ohio, May 3-6, 1951, the following took office for 1951-1952: president, Dr. Robert P. Knight; president-elect, Dr. Ives Hendrick, secretary, Dr. LeRoy M. A. Maeder; treasurer, Dr. William G. Barrett. At the business session the Brill Memorial Medal was presented to the retiring president, Dr. M. Ralph Kaufman.

The next meeting, the usual midwinter session, will be held at the Waldorf-Astoria Hotel, New York City, December 6-9, 1951; the next annual meeting will convene at the Chalfonte-Haddon Hall, Atlantic City, N. J., May 8-11, 1952.

AMERICAN LEAGUE AGAINST EPILEPSY.—At its annual meeting held at Virginia Beach, Va., April 13 and 14, 1951, the League selected the following officers: president, Dr. Francis M. Forster; vice-president, Dr. Benjamin Simon and Dr. John Kershman; secretary-treasurer, Dr. Jerome K. Merlis; chairman of program committee, Dr. Ephraim Roseman.

The 1952 meeting will be held at Louisville, Ky., during the week of April 21.

DR. MASSERMAN TO LECTURE IN EUROPE.—Dr. Jules H. Masserman, associate pro-

fessor of nervous and mental diseases at Northwestern University, and scientific director of the National Foundation for Psychiatric Research, has been appointed consultant to the Secretariat of the United Nations. In this capacity he has been designated by the World Health Organization to present a series of lectures at various universities throughout Europe, including Scandinavia, in October and November. During his stay in England Dr. Masserman will also address the British Royal Society on his research studies and their significance to dynamic concepts of personal and social behavior.

INTERNATIONAL COMMITTEE OF GROUP PSYCHOTHERAPY.—The advisory board of this newly formed committee, under the auspices of the Moreno Institute, consists of Drs. Joshua Bierer, London; Juliette Boutonier, Strasbourg; Jean Delay, Paris; Ernest Fantel, Camp Cook, Calif.; S. H. Foulkes, London; Georges Heuyer, Paris; E. W. Lazelle, Denver, Colo.; Marcel Montassut, Paris; J. L. Moreno, Beacon, N. Y.; Yves Porc'her, Paris; J. H. Pratt, Boston, Mass.

On the executive action committee for the French section are Drs. Leon Chertok, Victor Gachkel, Serge Lebovice, and F. Pasche; for the English section, Drs. Joshua Bierer and S. H. Foulkes; for the Austrian section, Drs. Erwin Stransky and H. Teirich; for the American section, Drs. J. L. Moreno, Joseph J. Meiers, Leonard K. Supple, and Rudolph Dreikurs.

The first International Congress of Group Psychotherapy is planned for the autumn of 1952.

National offices are as follows: Headquarters, Moreno Institute, P. O. Box 311, Beacon, N. Y.; France: c/o Mrs. L. Ostrander, 4 Rue Windsor, Neuilly s/s; England: Dr. Joshua Bierer, The Institute of Social Psychiatry Ltd., 9 Fellows Road, Hampstead, London N. W. 3, and Dr. S. H. Foulkes, 58 Portland Place, London W. 1; Austria, Dr. Erwin Stransky, Skodagasse 1, Wien VIII.

AMERICAN PSYCHOSOMATIC SOCIETY.—The ninth annual meeting of this Society will be held in Chicago, March 29 and 30, 1952. The program committee would like to receive titles and abstracts of papers for consideration for the program by December 1, 1951. Time allotted for reading of each paper will be 20 minutes. The committee is interested in investigations in the theory and practice of psychosomatic medicine as applied to adults and children in all the medical specialties and in contributions in psychophysiology and ecology. Papers accepted for presentation at the meeting will be submitted to the editorial board of *Psychosomatic Medicine* for possible publication in the journal.

Material for consideration by the program committee should be sent, in duplicate, to Dr. Roy R. Grinker, chairman, 715 Madison Ave., New York 21, N. Y.

At the annual business meeting held on April 28, 1951, the following persons took office: Dr. Roy R. Grinker, president; Dr. Sydney G. Margolin, president-elect; and Dr. Fredrick C. Redlich, secretary-treasurer. Drs. Walter Bauer, Henry W. Brosin, and Bela Mittelman were elected to Council positions.

SOCIETY FOR CLINICAL AND EXPERIMENTAL HYPNOSIS.—The second annual meeting of this Society will be held September 29, 1951, at the New York Academy of Sciences, New York City. All who are interested in the scientific aspects of hypnosis are welcome.

The first annual Review of Hypnosis will be published by the Society in early September. A limited number of copies wil be available to nonmembers at $1.00 per copy. Make checks payable to Dr. Hugo G. Beigel, Psychology Department, Long Island University, Brooklyn, N. Y.

ILLINOIS PSYCHIATRIC SOCIETY.—At the meeting on May 19, 1951, the following officers were elected by the Illinois Psychiatric Society: president, Dr. William H. Haines; vice-president, Dr. Jules H. Masserman; secretary-treasurer, Dr. Josephine M. Chapin; councillors, Dr. D. Louis Steinberg and Dr. Alfred P. Bay.

BOOK REVIEWS

FEELINGS AND EMOTIONS. The Mooseheart Symposium. Edited by *Martin L. Reymert.* (New York: McGraw-Hill, 1950. Price: $6.50.)

The Wittenberg Symposium on Feelings and Emotions was held in 1927 and its published proceedings are a landmark in medical psychology. At that meeting the titans (Cannon, Janet, Prince, Adler, *et al.*) of an older generation presented and discussed important papers. Little did they realize the import their work was to have in a few years on clinical medicine and psychiatry. "Psychosomatic medicine" was then in its period of gestation.

Martin L. Reymert was the editor of the book published in 1928 and he is the editor of the present volume. In the intervening 20 years it was his hope to bring together another such conference. The opportunity came to him through the generosity of the Loyal Order of Moose, who gave to his project their Golden Rule Award for the year 1948. With the cooperation of the University of Chicago, important psychologists, physiologists, and physicians were brought together from all parts of North America and Belgium, Holland, France, England, Norway, and Sweden. Forty-seven papers were presented, most of them short, averaging 12 pages. The two shortest are 5 pages; both come under the heading of Section IX: Emotions in Applied Fields. One is a discussion of "Feelings and Emotions in Art" by Langfeld, who says that satisfaction comes from the relaxation following discharge of tension, so the artist must have tension to start with. He considers "emotions" as stronger and more visible responses than "feelings." The other short paper is a descriptive clinical study of "The Emotional Stress of the Foreman in Present-day Industry" by Frisly of the Institute of Industrial Psychology in London. In contrast to these papers one finds in Section X: Methodology, a paper by Burt which discusses factorial analysis and its application to the study of the emotions.

The longest contribution is a 40-page paper by Wolff in "Life Situations, Emotions and Bodily Disease." This is in Section V: Emotions and Psychosomatics. It is a remarkably fine synthesis of Wolff's work of the last 10 years in this field and not only summarizes a great deal of research, but also puts forward an original formulation. This is the concept that the changes in bodily function following stress are not haphazard nor due to "organ inferiority" but are patterns of behavior in which are integrated as much of the organism's equipment as is needed for a particular protective effort. They are protective patterns of offense or defense, which are primitive and may be functioning effectively or may be conditioned by early life situations so that they later cause symptoms and even tissue damage. This is one of the most important contributions to psychosomatic medicine of the last decade.

Of equal importance in another field (Section IV reviews integrating current experimental approaches) is Bard's paper on the nervous mechanisms involved in the expression of anger, as studied in experimental animals that display rage, sham-rage, and docility.

It is not possible to pick out and discuss the best papers of the 47. The reviewer can merely show the scope and variety of the contributions and indicate thereby the great value of the book. Other sections are: I: Theory, Psychophysiological Approaches; II: Theory: Psychological Approaches; III: Reports of Recent Experiments; IV: Personality Dynamics and Clinical Psychology; VII: Emotions and Human Development; VIII: Emotions and Social Behavior. Obviously this is a book that should be in the library of every psychiatrist and physician who has an interest in the psychosomatic field.

S. C.

PHYSIOLOGY OF THE NERVOUS SYSTEM. Third Edition. By *John F. Fulton.* (New York: Oxford University Press, 1949.)

Since the first edition of this book appeared in 1938 it has become a valuable source of information. The general format of the present edition is like that of earlier ones, but because of extensive developments in the past 6 years considerable new material has been added.

The book begins with a brief discussion of receptors and of peripheral nerve and then considers the motor unit and synaptic conduction. The chapter dealing with the synapse, written with the assistance of David Nachmansohn, contains an extensive review of the physiology of acetylcholine and its rôle in the nervous system. Aside from this material on acetylcholine there is, however, little information on neurochemistry and the subject of cybernetics is not mentioned at all.

Physiology of segments of the nervous system is considered in successive chapters working cephelad from the spinal cord and including the medulla, the pons and midbrain, the autonomic system, the hypothalamus, the thalamus, and the cerebral cortex. Approximately 200 of the book's 643 pages deal with the physiology of the cerebral cortex, and the last 3 chapters discuss the basal ganglia and reticular formation, the cerebellum, and the nervous system as a whole as reflected in studies of the conditioned reflex.

While Fulton's approach is with reference to the normal physiology of the nervous system as elucidated by animal experimentation, frequent comments with reference to neurological disorders in man are given in the course of the discussion. Because of the author's competence as a medical historian, the book gives an unusually good perspective of the development of ideas. Each chapter begins

with a section briefly reviewing the history of the topic to be discussed, with the body of the chapter dealing critically with the more recent experimental work. There is also a helpful summary at the end of each chapter.

The author has included in this third edition significant developments of the past 6 years in several fields, such as recent discoveries of the inhibitory and facilitatory rôle of the reticular formation and its relation to the cerebellar cortex and cerebellum; new findings concerning the rôle of the orbital surface of the frontal lobes, the tip of the temporal lobe, and the anterior cingulate in relation to the autonomic function of the forebrain; functional localization in the cerebellum, and certain other relevant matters. In Chapter 22 he reviews and summarizes functional localization in the frontal lobe and in the temporal lobes as elucidated by brain operations on men and animals, especially in the light of the development of lobotomy techniques.

While the volume is of primary interest to neurophysiologists, clinical neurologists should also find it of considerable value. The last chapter deals with conditioned reflexes and discusses the subject of experimental neuroses. The text is illustrated with 140 figures and is very well documented with citations to over 1,600 contributions to the literature.

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THE CEREBRAL CORTEX OF MAN: A Clinical Study of Localization of Function. By *Wilder Penfield* and *Theodore Rasmussen*. (New York: Macmillan, 1950. Price: $6.50.)

From the Montreal Neurological Institute in recent years has come an increasing flow of experimental and clinical data on the function of the brain in normal and pathological states. The studies of epilepsy in particular have been outstanding. The prime figure in this work has been Penfield, who, with a proper regard for Hughlings Jackson's work, has attempted to bring the same type of intuitive understanding to modern concepts of brain function. Utilizing his incomparable experience in the observation of exposed human brains, he has progressively formulated a comprehensive concept of nervous integration. In this latest monograph, Penfield and Rasmussen summarize the data obtained from both cortical stimulation and ablation in a group of 400 patients. There is a good description of the overall technique used in gathering the data, emphasizing the importance of the teamwork involving surgeon, electroencephalographer, anesthetist, nurse, artist, and recorder. They properly point out that without the active continued cooperation of the patient (who is locally anesthetized) much of the data would never have been obtained.

The organization of the sensorimotor cortex is presented in detail, from its mesial border adjacent to the cingulate gyrus over the convexity, and onto the Island of Reil. The latter part is concerned with the alimentary tract. They describe also a secondary sensorimotor area at the junction between the somatic and alimentary parts of the primary area and a supplementary motor cortex on the mesial surface anterior to the primary area, but the functions of these are not so precise and seem to deal more with bilateral and synergic movements. The primary visual and auditory cortices are also described, and like the sensorimotor cortex are shown to be involved with inborn and relatively simple and invariable functions.

In contrast, the rest of the cortex subserves acquired functions. Electrical stimulation of the temporal lobes may produce complex psychical experiences in the form of perceptual illusions, hallucinations, and dreams. The authors believe that the temporal lobes are essential to memory formation.

The importance of dominant frontal, parietal, and temporal areas in the function of speech is confirmed, and the authors suggest that other frontal and parietal regions are similarly important in the elaboration of other motor functions, albeit in not so dramatic a fashion.

Perhaps the most important hypothesis presented is that whereas the human cortex is assuredly a very refined instrument that distinguishes man from other forms by giving him a wider breadth of subtlety and nuance of behavioral tone, the authors believe that the tone emanates from subcortical pacemakers in the diencephalon and mesencephalon.

To any student of human behavior this monograph should supply a mountain of data and a host of challenging questions. This reviewer's only regret is the almost complete absence of electrographic tracings from the case histories, which are otherwise so excellently presented and so conveniently indexed. This book is a valuable possession and another fine example of the brilliant work done by the Montreal group, a labor that this reviewer feels merits consideration by the Nobel committee.

I. CHARLES KAUFMAN, M. D.,
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THE EOSINOPHILE COUNT IN HEALTH AND IN MENTAL DISEASE: A Biometrical Study. By *Finn Rud*. (Oslo: Johan Grundt Tanum Forlag, 1947. Price (Norwegian kroner): 20.00, postage 2.15.)

The eosinophile, in its new rôle as an indicator of adrenocortical function (under certain conditions), has once more attracted wide interest to itself. It is, therefore, a somewhat eerie experience to read a monumental work devoted to the subject of this cell and its behaviour and find it was written "before cortisone" and therefore makes no note of the modern knowledge and speculation that has burgeoned forth.

None the less, there is here a mass of data, together with an exhaustive compilation of the literature on the nature and functions of the eosinophile, the factors in daily life that may affect it, and its behaviour in a variety of psychopathologic states. There is also considerable valuable discussion and experiment on the methods of enumerating these cells, leading the author to the conclusion that a

method using a counting chamber and a special diluting fluid is most accurate.

First, investigation of 150 presumably normal people under various conditions revealed that the eosinophile count underwent constant and rapid oscillations through the day, but that the mean values exhibited certain trends. It was high early in the morning, fell to a minimum about midmorning, rose transiently about noon, leveled off and then rose again throughout the evening hours and the night to reach a high morning level again. However, tremendous individual variation was encountered, as well as variation in the same individual from day to day. No seasonal variations were noted, and menstruation did not appear to affect the count.

Coming then to states of disease, with particular reference to mental illness, the author first tries to clear the air regarding the findings in allergy, and the occurrence of allergy in his psychopathologic material. It occurs more commonly in those suffering from neuroses, and less commonly in manic-depressives and schizophrenics. It affects the eosinophile count, but not as uniformly or markedly as one might expect.

The matter of bodily habitus was also investigated, with the conclusion that the leptosome types generally had a higher count. He found that the eosinophile count tended to be highest in the neuroses, was not significantly altered in some other types of illness, but underwent significant fluctuations in manic-depressive disorders. Here the count is subnormal when the patient is ill and climbs as he improves. While a marked depression of the eosinophile count occurs a few hours after cardiazol, electric shock or insulin, the cyclic variations in the count during the course of the disease were no different in the patients who received these treatments than in those not so treated. He felt that the count at a given time had little prognostic value, however. He was impressed with the fall which occurred in epileptic attacks and migraine, and felt that this might have some diagnostic value. In all some 440 patients were examined.

The book is marred in places by errors in translation and confusing misprints but one cannot help being impressed by the tremendous labour and reading that are represented in it. The author is very conservative in the interpretation of his data, although he propounds some views that sound strange to our ears, in view of recent developments. His work should prove of interest to those who are using the eosinophile count, and may provide food for thought and investigation for those who are interested in the relation of adrenocortical function to mental illness and its treatment.

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Cell Growth and Cell Function: A Cytochemical Study. By *Torbjoern O. Caspersson.* (New York: W. W. Norton Co., Inc., 1950. Price $5.00.)

The Salmon Lectures for 1948, which are published in this volume, deal with experiments in pure science without any attempt to relate the findings to the field of mental illness. The first 77 pages give a detailed description of the technique of microspectrophotometric measurements of biological materials and the method of interpretation of measured data. The experimental results are considered under three headings. Two chapters discuss the organization of the system of protein formation in a normal metazoan cell and in the various phases of the mitotic cycle. The author next describes protein formation in tumor cells. The final section deals with the system for protein formation in lower animals and plants including yeasts and viruses.

Caspersson has endeavored to analyze by the aid of quantitative cytochemical procedures the endocellular processes accompanying growth and function of cells. Interest has been primarily centered on the phenomena leading to protein synthesis. The nucleolus-associated chromatin directs the nucleic acid metabolism and consequently influences the protein metabolic processes in general. The main function of the nucleolus is to participate in the protein synthetic processes of the cytoplasm. Apart from the changes in the nucleolus, the most conspicuous changes cytochemically, during the cytoplasmic protein synthesis, occur at the nuclear membrane where the large ribose nucleic acid masses occur.

Caspersson has illuminated a whole new field of intracellular protein formation and this book may be considered as a classic. However, it is unfortunate that the experimental findings are presented without historical background and with no attempt to relate them to contemporary work in the same field. The 107 references in the bibliography deal almost exclusively with articles by workers in Caspersson's laboratory. Some of these co-workers have been concerned with the application of his findings to clinical problems. The fundamental observations obviously open a new approach to the study of yeast, virus, and tumor cells. There are many who think that abnormal protein metabolism may play a fundamental rôle in the production of psychoses and neuroses. Studies pertaining to this problem are being made in Caspersson's laboratory, but they are not discussed in this book.

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When Minds Go Wrong. By *John M. Grimes, M. D.* (Chicago, Ill., published by the author, 1950. Price: $5.00.)

Dr. Grimes writes that "no psychiatrist ever told such a tale before, and that the distribution of this volume may end my years of effective service." His thesis is twofold: first, that mental disorder is a problem for teachers and sociologists, not doctors; second, that state hospitals are hopelessly corrupt and that they retain patients longer than necessary to assure a pool of cheap labor. The first chapter, captioned "The Sizzling Truth," says that "psychiatrists look on mental illness as the private property of a privileged profession." This is a little hard to take, since no specialty has been

as generous as psychiatry in opening itself to the adjunct professions.

The author contends that emotionally disturbed persons are easy to understand and that we make a mystery of them to preserve our monopoly. "The neurotic's life is as easy to read as a child's primer." As for dementia precox, Dr. Grimes says that "its origins are so simple, its treatment so logical that one marvels at the blunders psychiatrists have made." To prove this, he cites cases of schizophrenia that he cured by several educational interviews.

Dr. Grimes tells the reader that "doctors can release [state hospital] patients whenever they choose, but I cannot recall one who ever really tried." His thesis is that the doctors keep the patients confined as a source of labor and also to protect their own jobs. He asserts that, in state hospitals, "doctors are never expected to treat the minds of their patients. The idea that they do so is mythical." He condemns attendants and shock therapy with equal vigor. Attendants are described as "ignorant bulldozers whose incompetence, callousness and brutality beggar description." As for shock therapy, he says that "it is already on the wane" and that its institutional use "simply adds immense financial gain."

His solution is the discharge of all attendants and the setting up of unfenced small towns for the mentally ill. There, he suggests, treatment would be largely "educational and social rather than medical."

The author's sincerity and good intentions cannot be doubted. But good motivation is not enough. Here is a reckless book that, if read by families, would generate unjustified anxiety and sabotage both our treatment and personnel programs. Like many another well-intentioned project, it has an enormous capacity for mischief.

HENRY A. DAVIDSON, M. D.,
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PROBLEMS OF INFANCY AND CHILDHOOD: Transactions of the Third Conference, March 7-8, 1949. Edited by *Milton J. E. Senn.* (New York: Josiah Macy, Jr. Foundation, 1949.)

This monograph reports the discussions of the third conference called by the Macy Foundation in the interest of "more adequate provision for channels of interdisciplinary communication" by "bringing together . . . . a small group of investigators, representing in so far as possible all the branches of science which bear on a chosen problem." Whereas the focus of the preceding conferences was primarily on problems of infancy, this one was expanded to include those of childhood.

Three areas of interest were defined for discussion: "Anxieties of Mothers as Verbalized to Physicians," "The Psychological Situation of Mother and Child upon Return from the Hospital," and "Observations on the Emotional Reactions of Children to Tonsillectomy and Adenoidectomy." Each discussion was preceded by the presentation of a paper. With respect to the first two areas of interest, points made in the presentations and discussions seem essentially to be a continuation and elaboration of those initiated in the preceding sessions. The third area concerns children's reactions to operation prior to and following surgery. Not only is the paper of interest but the discussion that followed is particularly stimulating. It is to be hoped this presentation will serve to encourage more research in this important area.

In the main the reading of the transactions of the conference was stimulating and provocative. Occasionally the discussion seems to deviate from the topic under consideration. At times reference is made to discussion that may have been deleted during editing. These, however, are minor considerations. For once again the value of the multidisciplined approach to problems is demonstrated. As in the previous conference, many questions are raised that require further study and investigation.

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THE CHILD AND THE MAGISTRATE. Revised Edition. By *John A. M. Watson.* (London: Jonathan Cape, 1950.)

This book may best be summarized as a description of the method of administering Juvenile Courts in England and of some philosophical musings concerning the administration of justice directed toward juvenile and young offenders. The author in his description draws freely on his experiences as a Magistrate in one of the most active London Juvenile Courts. He describes legislation covering the English Court and the methods of its administration.

The author's interpretation of the psychological factors involved in the child's court appearance must be considered as an oversimplification of the problem, and although it is an interesting discussion it could hardly be considered unexceptionable interpretation. The writer's plea for a careful assessment of each individual problem and structuring a plan of treatment based on the findings of the disciplines of psychiatry, psychology, and social work are commendable points. Many students in the field of child psychiatry would doubtless take issue with some of the author's statements, for example, "Fear of punishment remains an effective factor in a child's upbringing." Regardless of the disagreement one might have with some of Mr. Watson's concepts, he does make some excellent suggestions for the consideration of Magistrates administering such courts. The description in his final chapter, "The Magistrate," in which he outlines the qualifications of a person filling this position, has many useful concepts. His criticism of the Magistrates, of whom he is one, is that they are not highly enough trained in the special problems of children and frequently not familiar enough with the treatment facilities that are needed for the problems before them. The book on the whole is of limited value to those who approach the problem of delinquency from a clinical point of view.

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CHILD TREATMENT AND THE THERAPY OF PLAY. Second Edition. By *Lydia Jackson, B. Sc.* (Oxon.) and *Kathleen M. Todd, M. B., D. P. M.* (New York: The Ronald Press, 1950.)

This small volume by two English authors utilizes the concept of the "total setting" in child therapy. Although designed to outline "therapy through play," the entire tone of the book as well as the specific explanations emphasizes the total approach method to child behavior and therapy.

In describing the procedures used in play therapy, great stress is placed upon detailed and comprehensive history-taking by the social worker. Indeed, the psychiatric social worker plays a key rôle in the therapy situation. The play therapist sees only the child. He avoids seeing the parents to provide the child with greater security that the confidences are not betrayed. The psychiatric social worker is the liaison betwen therapist and parents: she obtains the history, engages actively in changing the parental behavior and attitudes toward the child, and explains to the parents the need for patience and persistence.

Having obtained information about the child and his family setting, the therapist checks that information against the child's reaction in play. The child may express inhibition, destructiveness, immaturity, obsessional tendencies, hyperactivity, or other patterns in play that contribute to the final diagnosis of the personality problem. The fantasy material and dreams of the child are also analyzed in terms of the total picture.

The therapy, as outlined, is the weakest portion of this otherwise excellent book. A definite approach is made toward influencing the environment, toward explaining to the parents the meaning of the treatment, and toward helping them obtain insight into their own and the child's problems. The therapy through play has fascinating potentialities, and the reader gains the impression that the authors not only know whereof they speak but are extremely successful in their attempts. Yet, only the vaguest suggestions are given in this volume as to the specific procedures in such therapy. The principles outlined are sound, and one may hope that this book, valuable and to be recommended in its present state, will be enlarged in its third edition to provide specific statements and detailed descriptions of the actual therapeutic process.

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THE FAMILY IN A DEMOCRATIC SOCIETY. SOCIAL WORK AS HUMAN RELATIONS. Anniversary Papers of the New York School of Social Work and the Community Service Society of New York. (New York: Columbia University Press, 1949. Price: $3.75 per volume.)

These two volumes are collections of papers read at the 100th anniversary meetings of the Community Service Society, New York City. Their range in subject matter and in professions represented testifies to the breadth of modern social-work interest and to the diversity of disciplines on which social work is based. The first volume consists of about 20 papers dealing with family life and with family health, both considered from a variety of viewpoints by a variety of professions. The papers in the second volume, equally numerous, deal with the theory and techniques of social work, with training for the profession, and with some of the broadly philosophical questions with which social work is concerned.

There are numerous psychiatrists among the contributors, and quite a number of papers that are of psychiatric interest. In the first volume Dr. Thomas French has interesting comments to make about personal interaction in family life, and Dr. Ernst Kris talks about the roots of hostility and prejudice. Two papers on adolescence—one by Dr. Nathan Ackerman and one by Dr. Viola Bernard—seem of especial importance. They describe with unusual clarity and breadth of conception the developmental problems of that age period. Both of these experienced child psychiatrists say that psychotherapy with adolescents who are in emotional difficulty is feasible and worth while.

In the second volume, readers of this JOURNAL may find especially interesting 2 reports of attempts to improve the selection of individuals to be trained for the professions—one currently under way in the New York School of Social Work and one completed rather recently in 2 medical schools. In the latter study, reported by Dr. Henry Brosin, it was found that, of the various psychological tests employed, only those of the projective type, and only when combined with a personal interview, proved useful in identifying candidates likely to do well in medical school.

Attention may also be called to 2 papers that were especially well received by persons attending the meetings. One of them is by an economist, and one by a social anthropologist, Dr. Eveline Burns and Dr. Allison Davis. Together with psychiatry, these two disciplines form the basis of social-work theory.

Dr. Burns has many significant comments to make upon current social welfare measures and upon their relation to the economic well-being of both family life and society in general. Dr. Davis calls to attention the fact that the ways of life of the various social classes in the United States differ greatly. His paper deals chiefly with the contrast between the middle class and the "lower-lower" class. He shows that from birth children in the 2 classes are treated so differently by their parents and are taught to value such different activities that as adults they find it difficult to understand each others' behavior and motives. He urges social workers, most of whom are of the middle class, to try to learn more about their lower-class clients' ideas and feelings in order to be of more help to them. Psychiatrists may find his remarks of pertinence to their work also.

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PERSONALITY MALADJUSTMENTS AND MENTAL HYGIENE. Second Edition. By *J. E. Wallace Wallin.* (New York: McGraw-Hill Book Co., 1949.)

This book exemplifies the prevailing bankruptcy of college courses in mental hygiene and abnormal psychology. It is a masterpiece of educational dilettantism. This reviewer may be accused of psychiatric nihilism and is almost certainly a member of a small minority when he expresses the conviction that so-called formal mental hygiene, even as practiced by the most skillful and experienced psychiatrists, has little to offer and has, in fact, been oversold to the public in general and educators in particular. It is perhaps unfair, therefore, to blame this author for a fault that pervades the subject matter he is dealing with. He is criticized for uncritical acceptance of points of view that are themselves open to considerable question. Of course every effort should be made to bring the benefits of psychiatry and abnormal psychology to as many people as possible. However, many of the facts and theories dealt with by psychiatrists are capable of being instruments of damage if used uncritically. A teacher of psychology might well impose a critical perspective on a flimsy field and make a valuable contribution by such an approach, but this author has done nothing of the sort. Instead he has presented an encyclopedic discussion of so many factors relating to mental disease—psychiatry, abnormal psychology, neurology, endocrinology, etc.—that he has failed to treat any one competently.

This is probably the best of current textbooks on mental hygiene. It contains many valuable features. Unfortunately, they have been obscured by a colossal volume of data that have been reviewed but neither assimilated nor integrated. A student is not likely to gain an accurate conception of shock treatment, psychoanalysis, or any of the other methods of psychiatry from a study of this book, but may be dangerously misled into a false sense of security concerning his knowledge of these. The author has had a wealth of personal experience with certain categories of maladjustments and could have made a valuable contribution had he confined himself to a thorough and thoughtful presentation of his personal experience. Instead he has attempted to cover so much that he has in fact succeeded in contributing nothing except further confusion to an already befuddled field.

The author states that parts of the book were originally presented in the form of lectures to popular audiences. Perhaps that explains some of the glib case reports. These would be real women's club thrillers, and a lay audience might be flattered by its superficial comprehension of the mechanisms involved. Would it not have been better to have presented these cases with some further qualifications? The book contains a large number of illustrative case reports, most of which were prepared for the author by his own students. Most of the maladjustments described by these students appear to have resulted from accidents of environment; and it is doubtful if any mental hygiene program could prevent the occurrence of such traumatizing experiences. A naive, immature student reading these case reports might well ruminate on them to an unhealthy degree and be led toward dangerous preoccupations in attempts at self-analysis. There is no doubt that many maladjustments can be settled on a simple and direct level, but the implications in this study of case material are misleading in their simplicity. College students need guidance in their introduction to a subject, not volume.

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MODERN DISCOVERIES IN MEDICAL PSYCHOLOGY. By *Clifford Allen.* (New York: Macmillan, 1949.)

I have had an affection for this book since I read it in the early days of its first edition; the fact that it reappears in enlarged form shows that many others appreciated its qualities.

Dr. Clifford Allen has written an interesting introduction on the historical origins of modern psychiatric thought. Mesmer, Janet, Freud, Adler, Jung, Kretchmer, and the modern physical methods of treatment all receive attention. The book is meant as an introduction, and for medical students, general practitioners, and the educated lay public it fulfills its purpose in whetting the appetite for further reading from the good bibliography provided. The budding psychiatrist will also find it useful in orienting himself in a new field.

The best chapters are those on Mesmer, Janet, and Freud. Toward Jung there is some evidence of unfavorable bias and in the section on the physical methods the interesting philosophical considerations are to some extent sacrificed to brevity.

I recommend the book thoroughly. The title is misleading, but the reader should forget this when once he has purchased the book and, at the price at which it is offered, few should neglect the opportunity to read it.

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THE AUTOBIOGRAPHY OF WILLIAM STEKEL. Edited by *Emil A. Gutheil, M.D.* (New York: Liveright Publishing Corporation, 1950. Price: $4.00.)

In this book Stekel gives an extremely frank and detailed account of his life. Freud has commented that his colleague had remarkably few repressions. Perusal of his autobiography suggests that Freud's comment was an understatement. Stekel's story has great interest and value for the light it throws on the life of a remarkable man, on that of a number of other remarkable men, and on a remarkable movement.

He was one of the original five that assembled weekly at Freud's home for discussion of his theories and thus were the pioneers of the new school. "I was the apostle of Freud who was my Christ." At first "there was complete harmony among the five,

no dissonances." Later, however, as the circle expanded, "quarrels among pupils, discords, and questions of self-esteem replaced the former spirit of close friendship." Freud once remarked to Stekel, "When I look at my pupils, I get the impression that psychoanalysis liberates the worst instincts in human beings." Stekel describes those early hectic days, disagreements among members of the circle, conflicts with Freud, secession of Adler, Jung, and himself.

Stekel discusses in detail his professional life with numerous epitomized case histories, including his experiences as medical officer in World War I and during an extended visit to the United States. In many places the autobiography reads like a diary intended for the writer's eye alone.

The author devotes several pages to his controversy with Freud and indicates in some detail their points of divergence, a main one being Stekel's briefer "active-analytic" method as compared with Freud's years-long procedure. "There is such a thing as overtreatment in analysis."

For self-revelation Stekel's autobiography is invaluable. His restless temperament demanding constant vigorous activity caused one friend to nickname him "Quicksilver." Another said, "He's like a man sitting on a hot stove." Wrote Stekel, "I sit at the typewriter and my thoughts flow so rapidly that my fingers can scarcely keep pace with them."

When the Nazis invaded Austria Stekel fled to England. Freud was there too. They never met. Freud died first; then Stekel, by his own hand, just as did a little later in Brazil another great Viennese, Stefan Zweig—both casualties of war.

C. B. F.

TREATMENT IN PSYCHIATRY. Second Edition. By *Oskar Diethelm, M.D.* (Springfield, Ill.: C. C. Thomas, and Toronto, Ont.: Ryerson Press, 1950.)

Dr. Diethelm's first edition of "Treatment in Psychiatry" is so well known that the reviewer does not feel the need of elaborating on this second edition. It is Adolf Meyer's "common-sense psychiatry" approach brought up to date with the new physical, chemical, and other therapies. Several authors have helped with various sections of the book, to wit, the section on psychoanalysis.

Dr. Diethelm has covered a very broad field in this book of 574 pages, written for the medical student and as a reference book for general practitioners who need a broad general understanding of the principles underlying treatment as well as the more concrete treatment procedures in both hospitals and outpatient settings, including clinic work with children.

S. S. A.

RORSCHACH INTRODUCTORY MANUAL. By *George Ulett.* (St. Louis: Educational Publishers, Inc., 1950.)

This is a most ingenious "short cut" to the Rorschach method for clinical psychiatrists. It describes in a very simple manner how any psychiatrist can proceed to use the test on his own patients. It provides valuable tables and a quite inspired scoring template for dealing with the test performance. It gives enough of interpretative and diagnostic guidance to stimulate interest in using the method to develop one's own interpretative skill with practice and the help of the suggested further reading. It is oversimplified. It cuts many corners. It presents many valuable compromises, however, between the various scoring systems which are extant. It is too glib on the subject of clinical diagnosis, although this aspect is mitigated somewhat by the explanatory text. There is a danger that it may be used by psychiatrists as if they were in possession of the sensitive instrument provided by the more complicated use of the test materials in the hands of a well-trained and experienced worker. Such psychiatrists might blame the failures on the technique rather than on their own rough use of it. It is to be hoped, however, that it may become widely used as an initiation into Rorschach possibilities, to be followed up by more intensive study and supervision with the method, or by a more judicious use of referrals to clinical psychologists for Rorschach examinations than the psychiatrists previously could have made. Its use could be compared to the employment of rough test papers for detecting sugar in the urine in comparison with quantitive urine and blood studies of glucose, evaluated by a biochemist. This reviewer is in agreement with Karl Menninger, who is quoted in the foreword as follows: "This is the most practical manual to serve as a primer to the psychiatrist that I have seen." Why Dr. Menninger's name is enclosed in quotes, while his statement has quotation marks only at the beginning, is something that remains for the author to explain!

W. DONALD ROSS, M. D.,
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THE MEANING OF ANXIETY. By *Rollo May, Ph.D.* (New York: Ronald Press Co., 1950. Price: $4.50.)

This book on anxiety, a nuclear problem in life and in psychiatry, aims to summarize and synthesize the best that has been written on the subject—a high order indeed. Included are concepts from current schools of dynamic psychology, academic psychology, biology, anthropology, economic theory, and philosophy. The summaries are intertwined with the author's critical evaluations stemming from his own orientation and illustrated by his own case material.

How unbiased his synopses are in the enumerated fields I am unable to judge save in the one field of my experience—psychoanalysis. Since it undoubtedly contributed most toward the elucidation of anxiety, the author's treatment of psychoanalysis would constitute a fair criterion for judging the depth of his insight and the objectivity of his effort as a whole. I must say that here the bias against classical psychoanalysis is deep, at times extreme. Early Freudian formulations in general and those of anxiety in particular are unduly

stressed, at the expense of later, more comprehensive ones. Granted that Sullivan, Horney, and Fromm wrote explicitly on anxiety, a number of classical analysts, a list too long to mention here, have also shed light on it in their work on problems of ego, schizophrenia, and of psychosomatic conditions. Apparently, psychoanalysis for the author is what is left after the libido theory and the structural conception of the personality, both regarded as outmoded nineteenth century thinking, are completely discarded and the distinction between conscious and unconscious mental processes deliberately blurred. Obviously the constricted residue is by the author regarded as an improvement over the operational concepts of present-day classical analysis.

The author does discuss lucidly many facets of the problem of anxiety, particularly in the realm of normal anxiety. He is more convincing when dealing with crises in normal development and particularly in relation to artistic creativity than he is with psychopathology proper. His distinction between the anxiety of progression or life and regression or death is useful. Though the distinction is well known, it is often obscured in clinical work by overidentification with the patient by whom both forms of anxiety are felt as a fear of death. Similarly helpful is the discussion of anxiety stemming from threats to the ego ideal. Also well covered is the general problem of the relation between anxiety and fear. However, the discussion of aggression and conflict is geared predominantly to conflicts between narcissistic trends. This area of conflict is important but is only one area and not the entire field, a criticism applicable to the book as a whole.

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Biological Foundations of Health Education. (New York: Columbia University Press, 1950. Price: $2.50.)

This volume consists of 14 papers relating to nutrition, psychiatry, gerontology, epidemiology, and sociology presented in 1948 at the Eastern States Health Education Conference organized by the New York Academy of Medicine and other associations. Clair E. Turner, Dr.P.H., introduced the general topic in "Health Education—Yesterday and Today." Four departments of the biological sciences are represented: nutrition, psychiatry, gerontology, and epidemiology.

That Roget and Latham's clear statement of dietary deficiencies found in prisoners in the main English penitentiary in 1822 is instructive in pointing up many of the issues in the early history of deficiency diseases, was Kruse's introduction. That economic forces influence the diet is well known and surveys of nutritional status with identification of malnourished persons have an even closer bearing on the problem. A further point was that the proportionate prevalence and severity of the signs of malnutrition increased with age. Kruse's conclusion was that many environmental factors inside as well as outside the body exert influences upon nutrition, which in turn reflects in health and welfare. In this relationship nutrition is seen to signalize the influence of environment on health and welfare and to occupy a key position as the crucial medium between them.

Tisdall emphasized the significance of the rate of growth of infants and children as an indication of the adequacy of their diet—an excellent example of obtaining evidence of the positive characteristics of their health. A study was made in Toronto to determine what effect diet has on the health of the pregnant woman and her ability to produce healthy offspring. It was found, first, that there were 3½ times as many premature infants born to mothers in the Poor Diet Group as to mothers in the Supplemented Good Diet Group, and second, that 14 babies were lost—7 from miscarriages, 4 from stillbirths, 2 from pneumonia, and 1 from prematurity, with every infant lost coming from the mothers who had been poorly nourished during the prenatal period. The tribute paid in the Foreword to the late Dr. Tisdall, whose paper is published posthumously, will be appreciated by his family and Canadian confreres.

It is only in recent years, writes Stare, that we have come to realize the importance from the standpoint of national health of bridging the gaps between nutrition, diet, and health. Research must be so interpreted that the public is made aware of the importance of good nutrition in providing better health. Growth and well-being in the newborn (!!) are distinctly influenced by nutrition. "The fact seems strange," wrote Herbert Spencer 100 years ago, "that mammas who have been taught little but languages, music and accomplishments are held competent regulators of the food, clothing and exercise of children. Meanwhile the fathers read books and periodicals, attend agricultural meetings, try experiments, and engage in discussions, all with a view of discovering how to fatten prize pigs." Stare concludes his summary hopefully: "Education in food and nutrition is beginning to play a major rôle in health education and is assured an even more important rôle in the health education of tomorrow."

Theoretically, psychology should be the study of the whole of the working of the normal personality, states Lemkau. We do not get a picture of the healthy individual only by imagining one without symptoms of disease. The normal human being is a person with assets. First we shall have to study the variations in man himself; second, the relationship between the various types of beings and other varied human beings; and finally the nonhuman setting in which the person lives—the ecology of man. Stevenson describes the psychiatrist's point of view regarding health and health education and compares it with the narrow concepts of disease and its causes of those engaged in health education or even in the practice of medicine. All this, he concludes, is in part the psychological warp of health education, permeating the whole of the process and all concerned therein.

Adequate health education is the greatest force available to preventive geriatrics, writes Stieglitz.

As health is a privilege and not a right, it entails the inevitable responsibility of effort to preserve it. As aging involves growth, the young adult must prepare for his senescence and ultimate senility (especially does this warning apply to structures that have poor regenerative capacity such as the cartilage of joints (E.S.R.)). It is desirable for the child to prepare for adulthood and for the adult to postpone his senescence and senility by the kind of life he lives.

"In the process of growth of a multicellular organism," writes Schaffenburg, "two groups of phenomena may be distinguished—these are the developmental and the anabolic phenomena. Among these are included cell proliferation, differentiation and organization. It is generally assumed that an individual grows and develops uniformly organically and in function up to an optimum of maturity, and from there on involutes in a gradual descending slope to the time of his death." The fact that the growth processes in living organisms, man included, continue throughout the life-span and are the basis of healing seems to have escaped the author's notice, as does the fact that the rate of healing is dependent not only upon the age of the person and the size of the wound but also upon the standard of his health as a whole.

As "epidemiology is the science concerned with the study of the factors and circumstances associated with the occurrence of disease among the people," its inclusion in health education to the lay public, and especially to children, is questionable.

This book should be widely read by the proponents of health education, for its contents are well stocked with much knowledge of the significance and utilization of sound facts concerning health.

E. Stanley Ryerson, M. D.,
Toronto, Ont.

1950 Year Book of Neurology, Psychiatry, and Neurosurgery. Edited by *Roland P. Mackay* (Neurology), *Nolan D. C. Lewis* (Psychiatry), and *Percival Bailey* (Neurosurgery). (Chicago: The Year Book Publishers, 1951. Price: $5.00.)

The Year Book begins its second half-century with a slightly larger format of distinguished appearance and new cover design.

A special feature has been introduced in that each of the three divisions of the book is prefaced by a review of progress in that field during the decade 1940-1950 by the editor of the division. Otherwise the coverage and arrangement remain essentially as in recent years.

In Mackay's summary view frontal lobotomy "deprives the subject of much emotional intensity and color and of much intellectual vigor and capacity for self-criticism. There is, however, growing doubt as to how permanent such deprivation is."

Mackay suggests replacing the term "psychomotor seizures" by the more descriptive clinical one "epileptic automatisms." "These seizures are not of 'psychic' origin, nor are they notably 'motor.'"

The work of the Veterans Administration in neurologic rehabilitation is one of the most significant movements of the past decade. In study and treatment centres for paraplegics, epileptics, aphasics, and other neurologically disabled types it has been shown that a much larger number of patients can be retrained and returned to community life than was previously thought possible. This is one of the most gratifying accomplishments of contemporary neurology.

Lewis points again, as he did last year, to "the unsoundness of much of the psychiatric propaganda that has swept and still sweeps the country . . . . and which has probably created more anxiety among the unstable than it has made psychiatric aid available."

In neuropathology Lewis calls for more study of brain changes associated with various somatic diseases. He calls attention to the fact that many earlier descriptions of brain pathology, assumed to have causal relationship to certain psychoses, neglected the possibility of brain changes secondary to physical disease, and that might therefore have no direct relation to the mental disorder.

The growing interest in social factors in the etiology of mental illness is bearing fruit, and more study of primitive peoples is needed, and promptly, if any are to be found uncontaminated by their civilized neighbors. "It remains to be determined whether the classic so-called 'functional psychoses' appear at all among the most primitive or belated peoples."

Preventive psychiatry must still be kept as a goal although at present its foundations are feeble. "The causes [of mental disorder] are unknown, and therefore accurate means of prevention are uncertain."

Bailey opens the section on neurosurgery with an excellent brief outline of the history of this specialty beginning with the work of Chipault, who published a treatise on the subject in 1894. It was Cushing who inaugurated the modern era. As in the other sections of the Year Book, so here the important studies of the decade and particularly the improvements in technique are passed in review. Bailey reiterates disappointment that civilian paraplegics are still deprived of the rehabilitation facilities available to veterans similarly afflicted.

Referring to personality changes following frontal lobotomy Bailey raises the question "whether the surgeon has the moral right thus to alter the personality of a human being without a judicial inquiry and legal authority."

While expressing justifiable pride in the accomplishments of neurosurgery during the first half of the 20th century, Bailey cannot forego a closing jeremiad. There are two clouds on the horizon: "One is the alarming increase in the number of neurosurgeons, which may bring doubtful practices in its wake, and the other is the incredible stupidity of the human race which seems to be unable to devise any way to save itself from suicide."

In its 50 years of publication the value of the Year Book as a convenient work of reference has been so well established as to require no commendation from the reviewer.

C. B. F.

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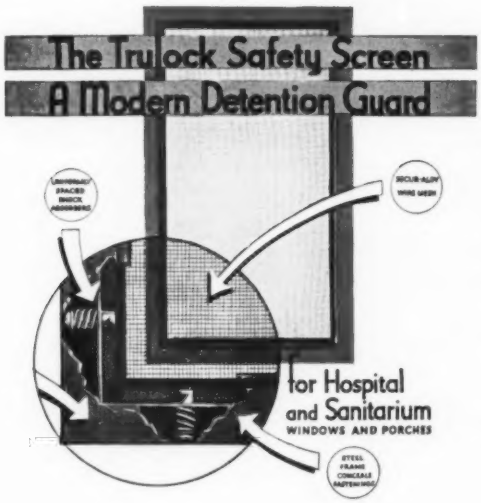

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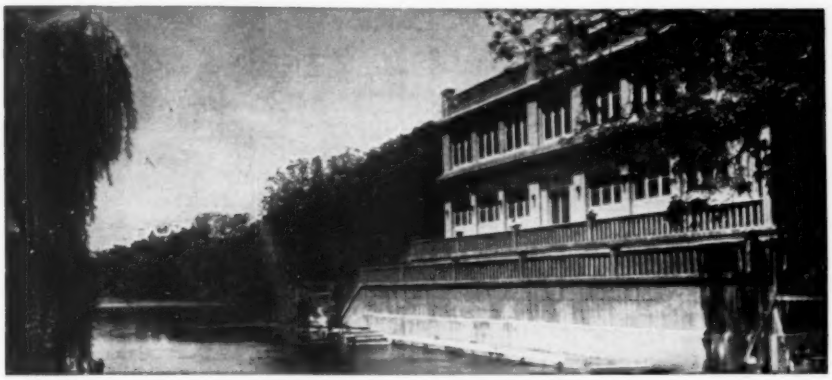

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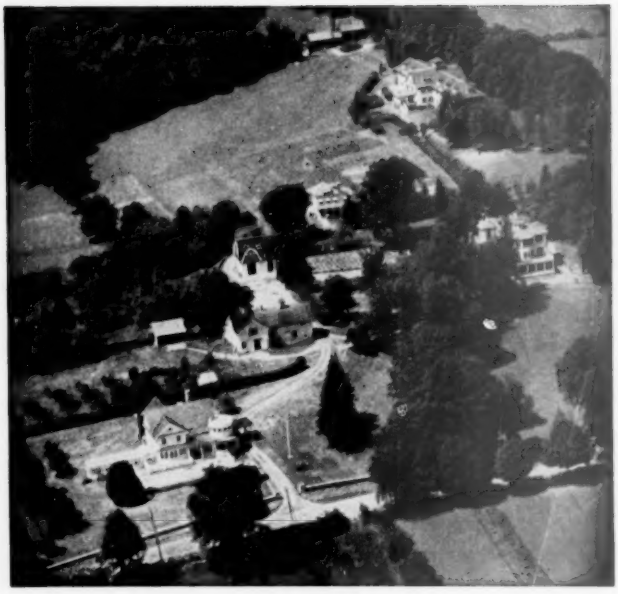

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